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Tenancy Sustainment Team health research: morbidity and mortality amongst people with experience of rough sleeping

Findings report

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Thames Reach

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Executive summary

Introduction

- This report presents the key findings of a small-scale research project exploring the mortality and health needs of clients of Tenancy Sustainment Team (TST) services. The research was commissioned in response to concerns by the Greater London Authority (GLA) and TST service managers about premature deaths among TST clients and the need to learn more about the health needs of this group, particularly the incidence of chronic or long-term health conditions (LTCs).

- TSTs at St Mungo's and Thames Reach provide floating support to people who have experience of sleeping rough in London. The TSTs are commissioned by the GLA and are attached to Clearing House accommodation which provides dispersed social rented accommodation across London.

- Qualitative research explored the views of TST workers on the health of their clients and the circumstances of client deaths; consulted current TST clients about managing health problems, and analysed existing data collected by the teams. The scope of the study was limited by budget and did not, for example, include qualitative fieldwork with people working in health, social care and drug and alcohol services.

Complex health and care needs and mortality

- A significant minority of TST clients have complex health needs, some when they start their tenancies, and others developing more complex health needs as they get older.

- Poor health is often related to earlier experiences of homelessness, and factors such as alcohol dependency or drug use.

- The quality of data on client deaths has some limitations but provides useful analysis that could be built upon going forward.

- The average age at death amongst TST clients (52 years) is higher than the average age at death amongst homeless people (47 years); these figures are not age-adjusted and the comparison should be treated with some caution.

- For approximately half of the deaths, there was no cause of death documented on the TST teams' systems. However, the most common recorded cause of death among the 55 people who died between April 2016 and August 2018 was cancer, followed by cardiovascular and gastro/liver diseases. Since these conditions can potentially be treated, some of the deaths may have been preventable.

- The findings suggest that drug and alcohol use are a key contributing factor in many of the client deaths. This can lead to chronic health conditions. The stigma attached to drug and alcohol misuse can lead to difficulties in accessing support from non-specialist services.

- TST staff also believed that social isolation, exploitation and abuse, and bereavement were factors exacerbating physical health problems.

Managing complex health and care needs

- TST staff work with clients who have complex health and care needs in a proactive and flexible way, focusing for example on nutrition (e.g. checking there is food in the cupboards, suggesting things to eat, encouraging use of meal replacement drinks); supporting access to medical care; and continuing to raise safeguarding alerts, where appropriate.

- However, staff described significant challenges. Reasons included high caseloads; a lack of proactive, flexible joint working from other agencies (including GPs and drug and alcohol services); and challenges locating and securing the engagement with clients.

- Getting coordinated support from a range of agencies was perceived as particularly difficult. This was thought to be particularly the case for clients with high needs linked to drug and alcohol use. In some cases, care packages were obtained from adult social care following referral from a TST worker. However, there was little evidence that new service delivery models for integrated care and neighbourhood multi-disciplinary team-working, are accessible to TST clients and practitioners.

- The extent to which staff felt supported around client deaths varied. Some felt at risk of criticism with little space to come to terms with the event. Others said they were well-supported by managers and colleagues. Staff said that ensuring the culture, conversations and atmosphere around client deaths were supportive and constructive was as important to them as availability of phone counselling.

- Feedback from clients of the TST service emphasised the health benefits of TST support and stable housing. In some cases, participants had themselves experienced complex health and care needs. They said that the TST had been a major factor in helping them move towards self-management and care.

- Isolation was reported by clients as being a major risk factor for health. Paradoxically, this was sometimes exacerbated as clients' support needs became less and the intensity of support from their TST worker thus reduced.

Conclusion

- People who move into Clearing House accommodation are no longer homeless. Consequently, they benefit from the stability of having their own tenancy and support from a TST. However, risk factors persist and the impact of homelessness and other disadvantages can be seen to impact on longer-term health and wellbeing.

- Our small-scale study suggests that many TST clients go on to lead fulfilling lives, entering education, training and employment, yet some are dying prematurely from conditions that could potentially be amenable to treatment. This highlights the need for better identification of those in the TST cohort with complex health and care needs, and provision of more targeted support from the wider integrated care system. This is with regard to physical health and long-term condition management, especially for more common conditions such as cardiovascular and respiratory disease.

Recommendations

- Part of the remit of the research was to make practical recommendations for the TST team and commissioners in the development of the TST service. Please refer to Chapter nine of the report for the full set of recommendations. These include the following:
  - *Practical health and care-specific recommendations for Thames Reach, St Mungo's and the TST teams* include: seeking funding for a health-screening pilot and/or additional clinical support service for the teams; proactively linking with hospital discharge teams when clients receive hospital inpatient treatment; continuing to raise safeguarding alerts and seeking Care Act assessments, as appropriate; and reporting any inadequate responses to these requests to local authority managers.
  - *Recommendations about practical aspects of engagement and TST support work and enhancing social networks* include: ensuring staff have access to and use interpreting services and travel funds, as appropriate; sharing best practice within teams around strategies to help enhance social networks; linking clients to befriending services or seeking funding for a TST-specific befriending service.
  - *Recommendations about supporting staff when clients face chronic health needs or die* include: acknowledging loss and ensuring that managers check in with staff members to explore how they are managing and feeling around the time a client dies, even if they appear to be coping well; referring to a counselling service if appropriate; as much as possible ensuring an atmosphere of learning and reflection around client deaths to prevent a sense of blame and feeling of scrutiny; and implementing reflective practice for TST teams in line with the aspirations of both organisations to deliver psychologically-informed environments.
  - *Recommendations for commissioners of the TST service* include: ensuring that the out comes the TST service is monitored against, reflect that some TST clients will have complex health and care needs; exploring with Clinical Commissioning Groups (CCGs) across London what (if any) arrangements there are for new ways of working around chronic care management and integrated care; integrating TST-specific health-related services for the TSTs to draw on, the benefits of which can be seen, for example, in the occupational therapist working with one of the teams; undertaking work to improve the quality and ease of compiling data on client deaths; working with partners to ensure that access to health services, including screening and preventative services, primary care and mental health services is central to the design of interventions for people with experience of rough sleeping.
  - *Broader recommendations for the Government, local government and health stakeholders* include: public health commissioners championing collaborative working and seeking new ways to support those who are in active addiction posing an ongoing, critical risk of death; provision of specialist supported or sheltered housing for people with long-term drug and alcohol use and health support needs; and increasing the flexibility and accessibility of the GP services, mental health services and drug and alcohol services for those who have complex health and care needs.

1. Introduction and methodology

1.1 Introduction

This report presents the key findings of research conducted between July and November 2018 into the morbidity (health problems) and mortality of clients of the Tenancy Sustainment Team (TST) services. The research aims to increase understanding of this area and to identify ways to improve the response to clients' health needs and deaths. The project was commissioned by Thames Reach and St Mungo's and funded by the Greater London Authority (GLA). The report is designed to inform the future development of the TST service in particular, but the analysis is intended to be relevant to homelessness and inclusion health sectors more generally.[1]

1.2 Methodology

The research was conducted by a multi-disciplinary team from the homelessness sector, health sector and academia. The methods used are summarised below:

- **Analysis of monitoring data:** data on client deaths from St Mungo's and Thames Reach were analysed, bringing together detailed information from the two teams for the first time. The analysis included data from April 2016 to August 2018. Additional information was provided by the Clearing House team.
- **In-depth interviews with TST staff:** qualitative interviews were undertaken with the most recent TST workers of 11 clients who had died in the preceding 12 months.
- **Focus groups:** three focus group discussions were conducted: two with TST staff and one with TST clients.
- **Expert seminar:** King's College London (KCL) convened an expert seminar to explore emerging findings. This was attended by a range of practitioners, experts by experience, clinicians and academics with an interest in homelessness and inclusion health.

The project was small-scale with some limitations. Qualitative fieldwork was undertaken with TST staff and clients. However, it was not possible to consult with a wider group of professionals, for example NHS and drug and alcohol services staff, about how the TSTs could better work with them. The study also used only the data collected by TSTs and the Clearing House and it was not possible, for example, to try to access death certificates for those clients whose information on cause of death was not of a sufficient quality.

1 Those who are in poor physical health in the TST caseload are relevant to the emerging field of research and practice known as 'inclusion health'. Inclusion health focuses on people in extremely poor health due to poverty, marginalisation and multi-morbidity. People supported by TSTs have a history of rough sleeping along with one or more support needs.

2. Background

This chapter provides background information about the Clearing House and TST teams, gives a brief introduction to the evidence on health and homelessness, and defines long-term conditions (LTCs) and complex health and care needs. Furthermore, it outlines information on some key current policy from the Department of Health and Social Care (DHSC) on the management of LTCs and complex health and care needs. Chronic care management and integrated care are two current policy themes with particular relevance to inclusion health groups including some TST clients.

2.1 The Clearing House and TSTs

The Clearing House refers to a pool of social rented accommodation designated for people who have experienced rough sleeping in London. The allocation of Clearing House stock is managed by St Mungo's, commissioned by the GLA. The TSTs are commissioned by the GLA to provide tenancy-related floating support (i.e. support in clients' homes or in the community) to around 1,700 people living in Clearing House tenancies. St Mungo's provides the TST North London service and Thames Reach runs the TST South London service. The TST service is designed to act primarily as a low-level preventative service. This gives floating support directed towards tenancy sustainment; access education; training and employment opportunities; and move-on to independent accommodation when clients no longer need the TST service.

Clearing House accommodation is designed for those who have low to medium support needs and will benefit from the low-level preventative support offered by TSTs. People are usually referred from hostels, but can also be referred when they are rough sleeping or accessing the No Second Night Out (NSNO) pan-London assessment centres. Since 2017, it has been possible to refer a small number of people with more complex needs to the Clearing House. This is known as the 'High Needs Quota' and accounted for around ten clients at the time of writing.

2.2 The evidence on homelessness and health

Multiple studies show that people sleeping rough and those who are single homeless, living in hostels and/or other short-term accommodation, die much younger than the general population. According to the Office for National Statistics (ONS) (2018), an estimated 597 deaths of homeless people occurred in England and Wales in 2017.[2] This represents a 24% increase in the last five years. The mean age of death of homeless people between 2013 and 2017 was 44 years for men, 42 years for women and 44 years for all persons. It is important to note that this is the average age of death for people who died while they were homeless. Homelessness is a temporary state for most people and the impact of a period of homelessness on life expectancy at a certain age is not known.

People with experiences of homelessness often encounter a range of challenges and barriers in accessing mainstream health care. These can include mistrust of health care professionals;[3] perceived stigma and discrimination;[4] competing priorities;[5] difficulties registering with GPs;[6] and difficulties making and keeping

2 Office for National Statistics 2018. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/deathsofhomelesspeopleinenglandandwales accessed March 2019.

3 Hakanson et al (2015); Collier (2011) Bringing Palliative Care to the Homeless, Canadian Medical Association Journal. April 5 18396 E317-E318.

4 Rae BE and Rees S (2015) The perceptions of homeless people regarding their health care needs and experiences of receiving health care, Journal of advanced nursing 2015; 71: 2096-2107. (2015).

5 Collier (2011) Bringing Palliative Care to the Homeless, Canadian Medical Association Journal. April 5 18396 E317-E318.

6 Fazel et al (2014) The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations, The Lancet. 384: 1529-1540. DOI: 10.1016/S0140-6736(14)61132-6.

appointments.[7] Moreover, unscheduled secondary care costs are eight times higher for patients who are homeless compared with those who are not.[8]

2.3 LTCs and complex health and care needs

An LTC is a condition that cannot be cured but is controlled by medication, treatment or therapies. Significant risk factors for physical LTCs are socio-economic deprivation in general, as well as specific features of adversity over the life course.[9] Disease prevalence increases in inclusion health groups across almost all conditions, and especially infections, mental health, and cardiovascular and respiratory conditions.[10]

It is well known that age-related functional decline and frailty, as well as hospital admission for a range of medical problems, tend to occur much earlier in life among people experiencing extreme forms of social exclusion.[11]

Tri-morbidity – the overlap of LTCs for mental health, drug and alcohol use and physical health – is strongly associated with homelessness.[12] Throughout this report we use the term 'complex health and care needs' to describe clients who have multiple (two or more) needs in the areas of physical health, mental health and drug and alcohol use.

2.4 Current policy guidance on effective management of LTCs and complex health and care needs

Lifestyle and ageing are two key contributing factors to developing LTCs. Improved public health, messaing/targeting, personalised care planning, information and supported self-management and care can help prevent and delay the onset, and slow the progression, of LTCs.[13]

It is the Government's vision that, 'Going forward … discussions about managing conditions become part of high-quality, personalised care planning and that this becomes the norm for everyone with an LTC'.[14]

In terms of local implementation of this vision, the DHSC recommends the use of Wagner's (2001)[15] Chronic Care Model (CCM).[16] The CCM is a complex intervention. It is based on the assumption that supporting people to better understand and manage their own conditions will slow disease progression which in turn will lead to fewer unscheduled acute hospital admissions.[17]

The CCM has been implemented widely across primary care in England as part of new service delivery models for integrated care. It uses proactive case management through a multi-disciplinary neighbourhood team. This brings together a wide range of different professionals. They include GPs, nurses, social

7 Rae BE and Rees S (2015) The perceptions of homeless people regarding their health care needs and experiences of receiving health care, Journal of advanced nursing 2015; 71: 2096-2107.

8 Office of the Chief Analyst. Healthcare for single homeless people. Department of Health, 2010.

9 Lee TC, Hanlon JG (2005) Risk factors for cardiovascular disease in homeless adults, Circulation 2005

10 Aldridge et al (2017) Luchenski S, Maguire N (2017) What works in inclusion health: overview of effective interventions for marginalised and excluded populations, The Lancet.

11 Cheallaigh (2018) Premature aging in the Homeless Population, Depaul.

12 Hewett et al (2016) Randomised controlled trial of GP-led in-hospital management of homeless people ('Pathway'), Clinical Medicine, 16(3) 223-9.

13 DH (2012) Long Term Conditions Compendium of Information. Third Edition. London: DH.

14 Ibid p15.

15 Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J and Bonomi A (2012) Improving Chronic Illness Care: Translating Evidence into Action, Health Affairs, 20, no.6 (2001):64-78 doi: 10.1377/hlthaff.20.6.64.

16 DH (2012) Long Term Conditions Compendium of Information. Third Edition. London: DH.

17 Ibid.

workers, pharmacists and mental health voluntary sector and housing advice professionals.[18]

At the same time, NICE (2016) guidance for the management of co-existing severe mental health problems and drug and/or alcohol use (dual diagnosis) envisages a personalised case management approach similar to that of the CCM. This sees mental health professionals talking the lead for care coordination and states:

> *'The care coordinator should adopt a collaborative approach with other organisations (involving shared responsibilities and regular communication) when developing or reviewing the person's care plan. This includes substance misuse services, primary and secondary health, social care, local authorities and organisations such as housing and employment services.'*[19]

18 An example of a local approach to the CCM is found in Southwark's Five Year Forward View of Health and Social Care 2016/17-2020/21 produced by Southwark CCG

19 NICE (2016) Co-existing severe mental illness and substance misuse: community health and social care services

3. Statistics on morbidity and mortality in the TST cohort

This chapter summarises monitoring data about client deaths and the support needs in the client group. The information was collected by the two TST teams and brought together and analysed by the research team.

3.1 Number of deaths amongst TST clients

Fifty-five people on the TST caseloads died between April 2016 and August 2018. Twenty-eight people were on the TST South (Thames Reach) caseload and 27 people on the TST North (St Mungo's) caseload (Figure (a)).

The average age at death was 52 years old. This was fairly consistent across the two teams: 51 years for one team; 53 years for the other. Five people or 9% of the group who died during this period were female; 50 people or 91% were male. This compared with 15% of Clearing House clients being female and 85% being male.

Figure (a) Client deaths by age

	Period			
	2016/17	**2017/18**	**April – August 2018**	**Total (whole period)**
Number of deaths	30	13	12	55
Average number of deaths per month	2.5	1	2.4	1.9
Mean average age at death	51	53	52	52
Age range	37-65	36-69	30-72	30-72

3.2 Cause of death

When a client dies, TSTs automatically implement their organisational standard procedure. For TST North, this is the Fact-Finding report, and for TST South, the Serious Incident Review. These procedures cover similar areas, for example which services were involved in working with the client. But they are not directly comparable. Both organisations do though record cause of death. However, there are limitations in the quality of recorded data on the cause of death of TST clients. In the analysed data, 'cause of death' was in many cases recorded as 'unknown' or 'natural causes', thus not providing the full detail that would usually be found on a death certificate.[20] In Figure (b) these cases are included as 'cause of death unclear'.

20 Death certificates record the (i) primary cause of death; (ii) secondary or underlying cause of death; and (iii) associated conditions. 'Natural causes' or 'unknown' refers to the manner of death (which can also be by accident, homicide or suicide).

In the majority of cases, entries on monitoring systems by TSTs are based on information supplied by housing providers or from coroners' reports or death certificates. In other instances however where this is not available, the team may use information supplied by the client's family. This is the case where for example the landlord is slow to complete their end-of-tenancy report and the team needs for procedural reasons to fill in their internal Fact-Finding or Serious Incident Review report. Also, the information source is not always clearly and consistently recorded.

A further challenge is that many deaths amongst TST clients are subject to a coroner's investigation and this can take several months. TST managers said that when workers contact coroners' offices about the death of a client, information is not always forthcoming.

In several cases where the cause of death was not recorded, records showed that clients were known to have serious underlying conditions, such as cirrhosis or heart disease likely to have contributed to their deaths or even be the cause of death. Better capturing the cause of death in the future will result in fewer cases where the cause of death is 'unclear'.

Despite these limitations, key themes relating to the death of TST clients do emerge and provide helpful insights into the health needs of the TST client group. Information is summarised in Figure (c). Most data is taken directly from TST North and TST South's own records, received by the researcher and later combined. Where the TST did not provide 'cause of death' data, information from the Clearing House monitoring system was used, as appropriate.

Overall, the most common recorded cause of death was cancer. Eleven people died of cancer (this included throat, mouth, oesophageal and breast cancer). Data relating to drug and alcohol use by the group was incomplete. However, it did show that three people had had past though not current issues with alcohol and drug use when they died; two had current alcohol problems, and one had a current drug problem, at the time of death.

Of the six people who died from cardiac problems, three were using alcohol heavily at the time of death. Their case notes suggest this was a factor in their chronic ill-health and death. All four of those who died from gastrointestinal and liver conditions were using drugs or alcohol: two were using alcohol, and two were using both drugs and alcohol. As alluded to, it is possible the number of people who died from gastrointestinal and liver conditions is higher, since a number of people had underlying liver disease which was not recorded as cause of death.

More detailed analysis of data from TST records shows that where 'the cause of death' was unclear, drug and/or alcohol use was often (in 12 of 28 cases) a key factor in the client's poor health, and generally very heavy alcohol use or intravenous heroin use.

Figure (b) Cause of death by age (for those with unknown or natural causes recorded additional contextual information drug and alcohol misuse is provided)

Cause of death – coded	Total	Average age	Age range
Cancer	11	52	40-72
Cardiovascular	6	52	30-69
Gastro/liver	4	51	36-65
Respiratory	2	55	49-60
Toxicity/drug overdose	4	48	37-59
Cause of death unclear - (heavy use of drugs and/ or alcohol around the time of death)	12	52	41-65
Cause of death unclear - (no heavy use of drugs and/or alcohol around the time of death)	8	53	41-71
Cause of death unclear - (not possible to assess use of drugs and/or alcohol around the time of death)	8	54	49-59
Total	**55**	**52**	**30-72**

3.3 Substance misuse profile

The prevalence of drug and alcohol use among people who died during the observation period is striking. Figure (c) provides more information on this. The data is compiled from reading through notes from Fact Finding and Serious Incident Review reports, and, where necessary, Clearing House data. The analysis of Clearing House data shows that the level of drug and alcohol use support needs among those who died during the observation period is higher than among all TST clients overall. Sixty-seven percent of those who died during the observation period had drug and/or alcohol use support needs. Our analysis shows that this is considerably higher than for TST clients as a whole. A review of more detailed notes from the monitoring data demonstrates how drug and/or alcohol use impacted on the development and then management of health conditions.

Figure (c) Substance-related support needs among clients who died between April 2016 and August 2018

Substance-related support need	Number of clients
Current alcohol use	16
Current drug use	5
Current both alcohol and drug use	9
Not a known problem for client	10
Past alcohol use	3
Past both alcohol and drug use	3
Data not available	9
Total	**55**

TSTs annually assess each client using an adapted version of the New Directions Team Index developed for the service. For this research, the data was used to estimate how many clients were likely to have complex health needs that put them at risk of increased morbidity, injury or death. People with a high support need related to drugs or alcohol, or physical or mental health, as well as those with co-occurring medium support needs, were identified. They accounted for 22% (321 people) of the TST caseload at the time of data collation. The same data was available for 46 of the 55 clients who died in the 18-month period analysed. Amongst this group, half (23) had either one or more high support need or two or more medium level support needs.

4. Client deaths explored in detail

This chapter presents findings from interviews undertaken with nine TST support workers about 11 clients who had died between January 2017 and May 2018. We refer to the cases included as 'case study' examples, as the circumstances of these deaths were explored in-depth in semi-structured qualitative interviews. As a caveat, it is important to acknowledge that TST staff did not have full knowledge of the health conditions that clients were experiencing. Case study examples were selected to include a wide range of clients. For example, those with different support needs, different lengths of tenancy, both men and women etc.

4.1 Age and cause of death

The average age of death among the TST clients who died was 56 years; most (nine) of the deaths were men. Causes of death included cancer, pneumonia and heart failure and in a number of cases were recorded as 'natural causes'. All the clients had been resident in Clearing House accommodation for between one and a half and 16 years, and on average six years. All were receiving TST support at the time of death, although some had not been in recent contact with their support worker.

Figure (d) Causes of death

Cause of death	Number of clients
Cancer (bone and breast)	1
Drug-related death – likely heroin overdose	1
Heart attack/cardiac arrest	1
Heart failure	1
Natural causes (no long-term drug use)	2
Natural causes (long-term alcohol use)	1
Natural causes (when being treated for a spinal issue and a gastro problem)	1
Not known – body decomposed	1
Pneumonia (following cancer remission and around the time of an assult by strangers in a public place)	1
Unknown/natural causes	1
Total	**11**

In eight cases, the TST worker felt that it was obvious that the client had been in very poor health at the time of their death. This was either due to illness such as cancer or very heavy drug and/or alcohol misuse and related multiple health problems, including overdose risk, poor nutrition and cirrhosis. In two cases (clients aged 57 and 71), death was considered to be completely unexpected. In one case, it was not possible to assess the health of the person around the time of their death because they were not in touch with the TST service at that time.

For eight of the 11 clients, alcohol and/or drug use was a key health support need implicated in clients' 'current' poor health and/or death. People were engaged with drug and alcohol services to varying degrees. People with cancer had ceased alcohol and drug use at the time of death. More generally, a theme emerged in the research of declining health being a strong motivator for reduction or abstinence from drug and/or alcohol use:

'She got cancer and she stopped drinking and using drugs. Before that she was […] drinking and used cannabis and crack.'

Themes to emerge in the responses about health conditions affecting clients at the time of their deaths were:

- Weight loss and poor nutrition were key concerns in supporting half of case study clients; several clients were prescribed 'Ensure' meal replacement drinks.
- Cirrhosis (liver condition), mobility problems, and breathing problems were mentioned in three or more cases.
- Recurrent abscesses, chronic pain, high blood pressure, poor foot health and diabetes were mentioned once or twice.
- Mental ill-heath was a concern for many clients: several interviewees specified that their client was depressed; one client had a history of suicidal ideation; no severe mental illness aside from depression was referred to in the interviews; two people had been recently bereaved and this had impacted their mental health.

The three people in our sample who were using or had used intravenous drugs died youngest. Each passed away in their 40s. For two of them, TST staff described very chaotic lifestyles in active addiction with risk factors including injecting, exploitation, injury and accidents. Both clients had safeguarding alerts made by the TST.

'He was always at very high risk of overdose. He had very bad varicose veins, […] problems with his bones, joints and muscles and blood clots; at some point I think he had DVT. He was underweight... the profile of a drug user with day-to-day use.'

The clients who had problems with alcohol but not drugs died in their 40s (1), 50s (2) and aged 60 (2). Those who were not using drugs or alcohol or a methadone script were the oldest among the case study clients when they died (aged 61, 70 and 71).

Aside from health and drug and/or alcohol use, several risk factors were identified as affecting the health and wellbeing of the case study clients in the period leading up to their deaths. These were: social isolation, bereavement, violence and exploitation, and issues with benefits. Three people had had safeguarding alerts raised in the year before their deaths.

4.2 Access to services

Six of the 11 clients included in the case studies were known to be working with their GP service; four people were hospital outpatients; two people had recently been in hospital, and one person was receiving hospital inpatient care at the time of his death. One person received hospice inpatient care at the end of their life.

The eight people who had had current drug and alcohol issues at the time of death were engaged with drug and alcohol services to varying degrees. Four had ongoing engagement (in one case this was intermittent); three had early-stage engagement following a period of ill-health. In the other case, the TST support worker had tried to connect the client with alcohol treatment for her to undergo a detox, but she had not attended the necessary appointments and had been discharged. This occurred on more than one occasion. Overall,

barriers to accessing drug and alcohol misuse services that were identified included: unrealistic expectations of clients' ability to attend appointments early in the day and consistently; and operating without the necessary flexibility for vulnerable clients. TST workers reported attending appointments with people where possible and where particularly critical. But their high caseloads meant they could not offer to do this on a regular basis:

> *'She was alcohol-dependent. I recognised this as a major issue and referred her to [the local alcohol service]… I took her to her first appointment, got her assessed, then the client has to make their own way back. I tried reminding her but she never went back… I re-referred her […] but she never attended.'*

TST support workers mentioned some other services that clients were accessing at the time of their deaths. One person had contact with the police and a domestic violence service. As mentioned, three people had had safeguarding alerts raised in the year before their deaths by the TST, demonstrating that the TSTs had serious concerns about their wellbeing. Responses from local authorities included referrals to domestic violence services and to drug and alcohol services.[21]

In most cases, the TSTs were aware of multiple health problems of their clients. In one case (the oldest person at 71 years), while there were no known health conditions, there was a significant language barrier to engagement.

4.3 The role of the Clearing House and TSTs in clients' lives

Almost universally, a stable tenancy with TST support was considered to be a protective factor in clients' health and wellbeing. Provision of good-quality, suitable accommodation, and the tenancy being valued by clients, were identified as key benefits. This in turn could motivate clients to maintain their benefits claim and engage with a TST support worker, even when they were struggling with alcohol or drug problems.

One case study interview, for example, described how their client's contact was very sporadic, but that anytime there was an issue with his Housing Benefit he would take action and get in touch with his worker to protect the tenancy he so valued.

TST staff also said that for some clients, there was a strong sense that the level of support provided by the TSTs was lower than was required. In at least two cases, the staff member felt that the client would have benefited from a move to sheltered housing. However, it should be noted that this would not necessarily have resulted in additional support without a corresponding care
package.

4.4 Challenges supporting clients

Challenges in supporting case study clients included: language barriers; locating and engaging with people very focused on using drugs each day or drinking heavily; unrealistic expectations of clients from other services, including drug and alcohol services (for example that they could consistently keep appointments or attend morning appointments); and problems accessing blocks of flats to enable workers to knock directly on the client's door.

21 A safeguarding alert can be made by a professional to a local authority in line with local protocols (often via contacting the local adult social care team) where there is a concern about an adult being able to live in safety and free from abuse and neglect.

Potential missed opportunities for improving clients' health across services included:

- Not accessing age-related screening programmes.
- Delay in accessing a chest X-ray due to a referral error.
- Lack of awareness of the seriousness of a flu-like illness in a vulnerable person with a long-term condition (by the person and their partner) and the need to seek urgent medical attention.
- Barriers to accessing drug services due to the services' inflexibility.

More analysis about supporting clients with complex health and care needs is presented in Chapter 5.

5. Working with complex health and care needs

This chapter draws on findings from focus groups with TST staff and the in-depth interviews about 11 client deaths to explore the key issues in working with clients who have complex health and care needs.

5.1 High support needs in the TST cohort

Clients with high support needs were described by TST practitioners as those who have complex health and care needs (e.g. deteriorating health linked to tri-morbidity and/or age) and/or social circumstances that may put them at risk of abuse and neglect. The intricate relationship between these two sets of factors often gives rise to the most challenging cases or 'complex' clients.

TST staff reported that the most common support needs and health conditions in the TST cohort were relating to drug and alcohol and mental health (often co-existing). Additionally, TST practitioners recorded a high incidence of post-traumatic stress disorder (PTSD), often linked to childhood trauma. This was perceived to be a factor in clients' mental health and drug and/or alcohol problems. In some cases this was the assessment of the TST staff as opposed to a formal clinical diagnosis.

Medical long-term medical conditions (LTCs) (neurological and other organ damage) resulting from alcohol misuse were reported as common. Other conditions found to occur often were: hepatitis C, HIV, cancer, diabetes, chronic obstructive pulmonary disorder (COPD), emphysema and arthritis.

Impairments in executive functioning (i.e. difficulty planning and organising), including those linked to acquired brain injury (ABI) were also found to be a reason for some clients needing support. Road traffic accidents which can cause ABI were noted as a cause of injury and disability in some clients, for example one case study client who had been run over while intoxicated.

Problems with the benefits system was most commonly identified among external structural issues that were risk factors to clients' health and wellbeing. Clients could become very fearful and anxious encountering these, especially where there was a possibility of losing their home. In one case study interview, the TST support worker described how this anxiety resulted in increased alcohol use.

Both female clients in the case studies of client deaths had experienced abuse. One had previously had a violent partner and the TST had helped her have him removed from the property when the relationship broke down. The other was a victim of familial violence perpetrated by her daughter and also possibly by her partner. One of these clients had also suffered an assault by strangers outside a shop just before her death from pneumonia. A male client had had a safeguarding alert because of threats of violence related to a dispute over money with an associate in the drug-using community.

TST support workers also reported social isolation as a key contributing factor to poor health and wellbeing, and in particular poor mental health and alcohol and drug use. Disabilities such as deafness and language barriers were also noted as contributing factors to isolation and loneliness.

5.2 Assessment of clients' needs

TST staff felt that the initial assessments of clients' support needs supplied by agencies referring into the Clearing House did not always provide the necessary level of information. Some TST practitioners also pointed to a lack of alternative 'housing with care' options. This they felt could result in people referring to the Clearing House 'playing down' clients' level of complexity and need:

> *'So the commissioning body needs to start looking at what suitable alternatives there are for people in hostels that have very, very complex needs that TST would not be able to deal with… Some of this client group have very complex needs and they will not sustain a tenancy.*'

One participant explained that sometimes LTCs not included on the referral information were picked up after a client had been accepted into the service. Examples included a heart condition where there was a risk that the client's needs could escalate quite quickly so that for example in the near future they would not be able to manage the stairs.

5.3 Caseloads

TST practitioners perceived that overall, new clients to the service had higher support needs than previously and that existing clients' support needs had sometimes escalated as they got older. Clients with the lowest support needs were more likely to move on to other accommodation following tenancy reviews by TSTs and housing providers. Meanwhile, although the number of clients with high support needs had increased, caseloads had not been reduced accordingly. As a result, TST workers described often having to work more than their allocated hours to ensure people received the support they needed. One TST worker said she had 'so many high needs cases… [clients] lose out because I can't give them the quality support they need':

> *'I have two current clients… both have got really bad deteriorating physical health. They have both engaged for four or five years with substance misuse services, but their health is basically a throwback to their substance misuse.'*

With caseloads of between 35 and 40, TST workers reported that they often struggled to practise effectively with those clients who needed an intervention rooted in a therapeutic relationship or psychologically-informed approach. Each staff member's caseload included clients with lower and higher support needs; the caseloads of senior practitioners in the services who specialise in working with people with higher support needs were slightly lower.

5.4 Multi-agency working

TST practitioners described many challenges in 'pulling-in' the appropriate level and breadth of ('wrap-around') multi-disciplinary support for their clients with complex health and care needs. This often left them working in isolation to manage extremely challenging and distressing cases, while at the same time trying to secure the care and support that was needed. Where mental ill-health co-occurred with drug and/or alcohol use, accessing services could be particularly challenging:

> *'I 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... [When he 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 several letters to his GP […] and contacting social services. Finally, he had a care package put in place.'

It was reported that GPs were especially hard to engage in multi-disciplinary working. Across health services more generally, information-sharing was a particular stumbling block. There was a sense that health professionals did not always understand the role of TST support workers. In contrast, specialist homeless GP and primary care services were said to be much more supportive and understanding of the TST practitioner's role and their client group. Some TST staff felt that more specialist health support attached directly to the TSTs could be very beneficial:

'[Specialist GPs] have a better understanding of the client needs and you realise that most of the clients that have had contact with such GPs don't want to change their GP. They'd rather travel across several boroughs to go there.'

5.5 Boundary spanning and extended job roles

TST workers often had to extend their job role beyond resettlement and tenancy sustainment work because they found it difficult to pull in the support of other agencies and professionals. Frequently, they were filling a gap while referrals were being made to adult social care. While not generally encouraged by TST managers, such 'boundary spanning' was sometimes essential to the health and wellbeing of the client.

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

The type of additional tasks outside the usual TST role cited by TST practitioners included:

- Supporting clients with nutrition and encouraging very underweight clients to eat; checking clients have money and food; ensuring meal replacement drinks and ideas about what to eat.
- Assisting with medication management (prompting and reminding people to take their medication).
- Assisting with cleaning and maintaining a healthy environment: 'We've had to help clients sometimes with cleaning because they've got hoarding issues or their hygiene might be quite bad'.
- Monitoring and welfare checks linked to domestic violence.

5.6 Relationship between stigma and self-neglect

The TST workers attending the focus groups identified a significant gap in service provision for TST clients whose long-lasting medical conditions (neurological and other organ damage) were a result of alcohol or other drug use. Such clients could often be excluded from services because they were perceived to be making poor lifestyle choices and/or going against medical advice by continuing to drink and/or take drugs. TST practitioners said they felt these clients were being 'stigmatised':

'When I had [a client] with cancer, there was a lot of support from other teams. With alcohol, when it's liver failure […] you get less support.'

'Some of our clients get the impression that they are being treated differently… They understand their health is deteriorating through their past drug use, but they're willing to engage [now] with all the services, but they don't think they get [the] full [treatment]… they deserve.'

5.7 Engagement

Feeling stigmatised and losing faith in 'the system' was cited as one of the main reasons why clients were often reluctant to engage and accept support.

TST workers said they wished to deliver a more intensive, proactive and psychologically-informed outreach service to clients with high needs. Locating clients and building up trust were key building blocks and, while time-consuming, this approach was key to moving the client from 'self-neglect' towards 'self-management and care'.

The first step they described was about securing access and contact with a client. Just tracking down clients and getting 'through the front door', especially when clients were living in blocks of flats was said to be extremely challenging.

Clients who were very focused on using drugs daily or drinking heavily were identified as being particularly hard to engage and to move beyond 'self-neglect'. Persistence, and establishing a trusting and compassionate relationship over time, were said to be key to 'inclusive practice' here. The trust that was developed could then be used to link clients to other services:

> *'You have to really try and build up a good relationship, then they may open up and tell you everything… If they trust me to be with them, then they will go for treatment…'*

TST practitioners reported that due to high caseloads, interventions rooted in the highly relational, continuous and empathetic practices they aspire to could not be routinely provided.

5.8 Palliative and end-of-life care[22]

Nearly all the TST practitioners we spoke to had experienced the death of a client. Some felt a huge burden of responsibility while supporting people who were sick. They worried about their clients when not at work and sometimes felt that they and their clients did not receive the help or support needed from drug and alcohol, health and social care services in a timely way. As such, they said their role went way beyond tenancy support:

> *'Tenancy support workers shouldn't be saving lives. We should be saving tenancies.'*

Given the complex health needs of some clients, some staff felt that there was an over-emphasis in their role on outcomes around employment, training and move-on:

> *'We have to get them employment, training... but for me [...] this person's health is more important… and keeping a roof over his head and making sure he's well enough to sign on or get his benefits so he's not back on the streets, so his physical and mental health don't fail...'*

TST workers recounted some positive experiences of clients with palliative care needs. For example, a client was able to access sheltered accommodation when their needs became too great to be managed in their own home. Other workers described being able to access support from nurses for clients with cancer, which enabled clients to stay in their homes and have access to TST support until the end of their lives, as was their wish.

22 Palliative care is the active holistic care of patients with advanced progressive illness. Management of pain and other symptoms, and provision of psychological, social and spiritual support, is paramount. End-of-life care is an important part of palliative care for people who are considered to be in the last year of life, though this timeframe can be difficult to predict. End-of-life care aims to help people live as well as possible and to die with dignity.

However, less support was available for people with advanced ill-health as a result of drug and alcohol use compared with those who had cancer, for example. The role of the occupational therapist in TST North was considered incredibly important in advocating for additional support for this client group.

Many of the clients who died were described as having complex needs. TST workers attending the focus groups said in retrospect the deaths were not surprising, but had often been unexpected nonetheless. This was in line with findings from case study interviews. Other TST practitioners said there were instances when clients had been 'fine' one day, and then they had found out that they had died shortly after, usually from drug-related incidents.

TST workers said there were times when clients had told them that they had 'saved their lives' by coming to their flats and finding them in the middle of a health crisis and calling an ambulance for them. Participants described feelings of guilt when clients died and they felt they hadn't been able to 'save' them.

5.9 Dealing and coping with a client's death

TST practitioners in the focus groups were asked about their experience of their clients' deaths. TST staff reported feeling shocked and sad when clients died, if not always surprised. Several interviewees described wondering, 'Could I have done more?' or feeling that if they had not been on leave for example things may have been different. These feelings were generally but not always ameliorated by feedback from colleagues or a period of self-reflection. It helped TST staff to reach the conclusion that death is likely to be an occasional and inevitable part of working with vulnerable people, and not a manifestation of the individual's work:

> *'You always ask yourself questions: what I could have done different, what else could we have done. Yes [I did share that feeling] with my manager. We have a good relationship – I was really supported. There is a moment when you think about [a] client and remember the situations. We had some nice memories.'*

Where clients were drinking alcohol or using drugs very heavily, it was common for a worker to feel a sense of impotency and sadness at the situation:

'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.' TST workers spoke of clients who were well-known to them with affection and remembered things about them that did not relate to their problems. Examples were that clients were 'well-liked' or 'handsome'. Or they remembered them sharing thoughts and interests such as books, or showing the staff member a photo of how they used to be or of their children. Several commented that it was good to think about and reflect on their clients who had passed away:

> *'I wanted to pay my respects. She had been through more than I knew about and I respected her as one human being to another. It felt essential and important [to attend the funeral]. I wanted to show I thought highly of her. She showed me a lot about human behaviour. She was lovely.'*

Overall TST workers felt supported in their workplace, although the sense of support was found to be more pronounced in one team than the other. Ways in which people felt supported or unsupported are further explored later in the report.

The experience was said to be far better when TST staff were given some time to take in the news, with the option of a day off work, and felt able to discuss the death with colleagues.

Following a death, some support workers described going into ‘panic mode’ or suffering from anxiety. They feared there would be in investigation, their contacts would be scrutinised and they would be deemed not to have done their job properly. They worried about their records not being up-to-date and being blamed for the death. One support worker however said that while they also felt they would be under scrutiny, this did not concern them.

Another TST worker compared a hostel setting, where there could be more support for a ‘team’ around the death of a client, and more involvement of managers, whereas for a TST worker the experience could be quite isolating.

Some TST workers described a ‘lack of space’ for discussion or reflection following the death of a client, although they said that managers and colleagues were available to talk about it. Workers did have access to a telephone counselling service but this was rarely used. One participant reported accessing bereavement support. Another participant described feeling very poorly supported around the time of a client’s death and that the focus had been purely on the examination of their work and then a new client being added to their caseload.

6. Reflections on health from TST clients

This chapter summarises findings from a focus group that was conducted with 16 current TST clients. People attending had a range of experiences of homelessness and support needs. The discussion explored how people living in Clearing House accommodation managed their health and wellbeing; their perceptions of the role of TSTs, and how outcomes could be improved.

6.1 Impact of rough sleeping on health

TST clients described how their health and wellbeing had been severely affected by living on the streets. They reported how even a small wound or cut could turn into a life-threatening infection due to lack of basic washing and cleaning facilities. However, the impact on mental wellbeing was thought to be most detrimental, having further serious consequences for physical health:

> *'[When living on the street] you lose your interest in life. It's a mental issue. You don't care about your liver; you don't care about your kidneys; you don't care about anything…'*

6.2 Engagement with health services

The lack of engagement with health services while living on the street was described as 'just the general can't be arsed'. Feeling stigmatised or having had negative experiences of trying to get help from services were identified as key factors in people's reluctance to engage:

> 'A lot of people that I know that are long-term entrenched rough sleepers have had a bad experience with services.'

6.3 Benefits of engagement with TST and support services

Being housed through the Clearing House was described as a 'great panacea', but something that could also bring a lot of pressures once the initial 'honeymoon period' was over. Participants in the discussion group described the value of good-quality support work to help manage this and the impact a good worker could have with regard to wider issues. One participant described very movingly how, when he was at his lowest, the fact his TST worker just came to sit with him was very important and saved his life.

Another participant described the invaluable role of St Mungo's Recovery College in his recovery from mental health and addiction issues. He noted in particular the usefulness of the Five Ways to Wellbeing Model (Connect, Be Active, Take Notice, Learn, Give).[23]

Participants involved with mental health services spoke of the value of having a personalised care plan. There was also some awareness among the group of concepts such as 'co-production' and 'patient-centred practice', and strong support expressed for this:

23 Information about the Recovery College https://www.mungos.org/our-services/recovery-college/ accessed December 2018.

There's a thing called a ladder of involvement that the services can do with their clients… Get that individual into recovery, get them owning something, make them proud, get them included… I'm powerless over law and legislation, rules and regulations, policy and procedure, but […] I tell [my worker] what I'm doing, he informs me of what's going on, stuff like this and I get ownership out of it.'

6.4 Self-management and care

Other participants described how they had been able to 'self-manage' their recovery without much in the way of support. Some said that once they were feeling better, they started to become health-conscious and to take control of improving their own health and wellbeing:

'I think like being physically active and having a healthier diet will change a lot about your wellbeing… From my own experience, I just started, like four weeks ago. I lost maybe eight kilo in a month… It's all about the willpower… I wake up six o'clock in the morning [and I go for] like 40 minutes' walk... I enjoy discovering new places, you know, and to be honest you become more positive… And trying just to eat healthy food.'

6.5 Social isolation

There was recognition that once clients were perceived to be 'doing well', there would be a reduction in support and less contact with the TST worker. This could result in social isolation which was described by clients as a 'massive problem' for people living in Clearing House accommodation:

'The main problem is isolation. 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. Some days I don't know how my depression is going to react or how I'm going to wake up… there are set backs, that's where you need extra support.'

6.6 Ongoing support

Ongoing low-level support was identified by the client focus group as key to maintaining any health gains and preventing fluctuations in health. Significantly, in the client-practitioner relationship, concerns about engagement seemed to work both ways. TST practitioners described the struggle to engage their 'high needs' clients, while clients with low-level needs described their struggle to (re)engage their TST workers:

'I've got about two visitors which visit me as friends and I found myself drifting back to areas where I can have company with the homeless again, which is detrimental because then it means that there's alcohol or drugs and the temptation… I think there needs to be more support… I know the support workers have got a heavy caseload. It's a lack of manpower.'

TST clients highlighted the value of peer support, given the workload pressures on support workers, but this was also said not to be enough:

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

'AA [Alcoholics Anonymous] keeps you busy for an hour, but what about the rest of time?'

The need for a purpose in life was also said to be key to combatting isolation and protecting mental wellbeing. Clients also welcomed support with getting into education, training and employment.

7. Recommendations

This chapter makes recommendations arising from all elements of the research.

7.1 St Mungo's and Thames Reach TST service providers

Recommendations for service providers are split into key themes. It is important to note that many will depend upon the resources and priorities of the teams and will be impacted by the way the service is commissioned.

Health and care-specific

- Support clients to access person-centred health care services in order to increase uptake of screening and individualised care planning.
- Proactively link with hospital discharge teams, such as the Pathway Teams and the Thames Reach's Croydon hospital discharge project, when clients receive emergency or inpatient treatment in hospital.
- Proactively link with primary care-led multi-disciplinary neighbourhood teams.
- Continue to raise safeguarding alerts and seek Care Act assessments, as appropriate, as a vital way of highlighting the needs of vulnerable people to local authorities, even though the response is not always viewed as comprehensive or adequate. Report inadequate responses to local authority managers.
- Ensure that all staff are trained in the Care Act 2014 and its relevance to supporting people with a history of homelessness and those with multiple needs, including good practice in making referrals for assessment under the Care Act, and the type of circumstances covered by the Care Act, including self-neglect.
- Ensure all staff are aware of and advise clients about age-related health checks and screening, even where uptake is low or unlikely. Ensure people are asked about what might make it easier or encourage them to attend.
- Seek to meet clients both inside and outside their property to help gain a picture of their confidence in different settings.
- Consider local day centres and other specialist services, as well as the Groundswell Homeless Health Peer Advocacy Service, where available, for clients who find it hard or do not want to engage with a local GP.
- Consider seeking funding for a health-screening pilot and/or clinical support service for the teams to add value to the commissioned service, and potentially show the benefits of this to attract longer-term funding.

Sharing information and highlighting needs

- Work with commissioners to create an improved data collection process for obtaining accurate and consistent information about the causes of client deaths.
- At quarterly meetings with the GLA, provide case studies describing 'high needs' clients to GLA commissioners to illustrate clients' needs; the efforts being taken to coordinate services made by the TST, and the response locally by health, drug and alcohol and other services.
- Ensure that next-of-kin and contact information for other family members or partners or friends is gathered and held by the TSTs (in line with consent processes).
- Request a Safeguarding Adult Review (SAR) via the Local Authority if it is believed that a client has died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect that person.

Practical aspects of engagement and TST support work

- Seek to link clients to befriending services to alleviate social isolation and encourage meaningful occupation of time, or seek funding for a TST-specific befriending service.
- Share best practice within teams around strategies to help enhance social networks, for example attending a social or cultural event (e.g. Age UK service) or leisure activity with a client for the first time.
- Where possible, and in agreement with landlords, ensure that TST workers can reach the front door of clients' flats; for example by having key fobs or codes to enable access to blocks of flats.
- Managers at all levels ensure access to interpreting services (including having flexibility for staff with language skills across organisations to assist with this), and funds for travel.
- Ensure that wherever possible freedom passes are obtained for those clients who qualify.

Supporting staff when clients are unwell or die

- Ensure that staff members are explicitly supported following the loss of a client, even when they appear to be coping well. Invite open dialogue, as well as referring to a counselling service, where appropriate.
- Seek to ensure an atmosphere of learning and reflection around client deaths.
- Implement reflective practice for TST teams in line with both organisations' aspirations to deliver psychologically-informed environments.

7.2 Commissioners of the TST service

- Ensure that the service specification considers the needs profile of the TST cohort based on best current evidence when recommissioning the TST service. Consider high support needs related to alcohol and/or drug use as health support needs: a client may not have a diagnosed medical condition but a high drug and/or alcohol use support need often poses an immediate critical danger to their health, and it is likely there are physical health needs that are neither apparent nor disclosed.
- Ensure that TST contracts are sensitive to the needs of all Clearing House clients, including those with higher support needs. For example, recognise that support to 'live well' may be more appropriate than moving towards Education Employment and Training for clients who have complex health and care needs; health and care support needs fluctuate over time; and some people will need to remain in the Clearing House long-term.
- Consider reconfiguring the 'High Needs Quota' approach (designed to bring Housing First principles to the TST service) to all clients who have high health-related support needs, as well as those specifically accepted into TST services as 'high needs'. This would mean providing more capacity within teams to undertake intensive and flexible support work with these clients.
- Seek ways to introduce funding for health-related services for the TSTs to draw on. Options for consideration are:
  - *In-house occupational therapy for the teams as per the current St Mungo's model.*
  - *Targeted nursing support for the TST to work with people who are frail or unwell, and to* help assess and enhance the teams' understanding of the health needs of current clients.
  - *Peer support, for example, though specific access to a health advocacy project such as that provided by Groundswell Homeless Health Peer Advocacy Service in some boroughs.*
- Try to ensure that clinicians working within teams are 'inclusion health' practitioners with the skills and experience to work effectively with people who have rough sleeping histories and people with drug and alcohol use support needs.
- Highlight the needs of the 'higher needs' cohort within the TST caseloads with other commissioning and policy colleagues in health, public health and community safety; and the paucity of joint, collaborative work in some cases, but good practice in others.

- Contact Clinical Commissioning Groups (CCGs) across London to confirm arrangements (if any) are in place for new ways of working around chronic care management and integrated care, initially targeting areas with the highest number of TST clients. This initial mapping could be further developed via a high-level seminar with CCG commissioners and integrated care leads to share the findings of this research about issues around access for marginalised groups. The Homeless Programme at the Healthy London Partnership (of which GLA is a part) would be able to assist with this.
- Consider working with partners to pilot a Chronic Care Model (CCM) for people with complex health needs in the Clearing House, in particular innovating by trialling Integrated Care Communities (ICCs) for TST clients with high support needs. This could be done across a sample of CCG commissioning areas and showcase multi-agency working targeted at people with rough sleeping histories.
- Work with providers to improve the quality of data and ease of compiling information on client deaths, for example considering a centralised role for the Clearing House Team in following up the cause and underlying cause of death as recorded on a death certificate.
- Consider a standard approach to requirements for reviews of client deaths across the two services to enable ongoing analysis. Key information to be compiled in one data source should include: the cause of death (as recorded on a death certificate with full details); location of death; whether palliative or end-of-life care were planned; whether drugs and/or alcohol use were believed by TST teams to be a contributory factor in a client's poor health. Since information from coroners often takes a long period to come through, it is important that other information known to the teams is collated and reviewed as quickly as possible rather than learning being delayed.
- Work with partners to ensuring that access to appropriate health services, including screening and preventative services, primary care and mental health services is central to the design of interventions for people with experience of rough sleeping, from outreach service and hostels to resettlement and medium-term accommodation such as the Clearing House.

7.3 Ideas for other stakeholders

- Specialist supported or sheltered housing for people with long-term drug and/or alcohol use and health support for those who are in poor health should be provided more effectively. This would aid organisations such as the TSTs in moving people on to appropriate accommodation when their needs are too high for their service.
- The Government and local CCGs should explore ways to be more responsive and flexible in supporting people into drug or alcohol treatment to prevent deaths related to drugs and alcohol.
- GPs should ensure that services are flexible and accessible to support patients with multiple needs.
- Public health commissioners should support collaborative working across health, drug and alcohol, and homelessness services to seek new ways to support those who are in active addiction where this poses an ongoing, critical risk of death.

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