



City of Westminster

FAIRER WESTMINSTER

Westminster rough sleeping
pathway – inclusion health teams
and partners

Fairer Communities

Fairer Housing

Fairer Economy

Fairer Environment

Fairer Council

westminster.gov.uk/fairer-westminster
#FairerWestminster

10.00	Aneemo PIE training - Emma
10.05	Additional health needs pathway
10.10	Women's health improvement project – Maggie
10.15	PiH Neuro psychology team – Lily
10.20	STEP Team update – Lily
10.25	Turning Point – Amelia
10.30	SHP floating support assertive outreach – Karen
10.35	Build on Belief – Liam
10.40	Change Communication – Leigh
10.45	SMD Caseload Nurses – Sharon and Moya
10.50	Nursing in reach at EAC, HAC and MORs – Sigrid and Chris
10.55	Dr Hickey Surgery - Paul

Additional Health Needs Pathway

In partnership with:

Great Chapel Street Medical Centre

Dr Hickey's Surgery

SHP

Lookahead

The Passage

Groundswell

NWL ICS

WCC

Criteria

Health beds	ICN beds	ICN Caseloads	Women's Health Caseload (no beds)
Male	Male or female	Male or female	Female (or identifies as such)
No registration criteria	Registered with GCS or DHS	Registered with GCS or DHS	No registration criteria
Rough sleeping in Westminster – <u>CHAIN record</u>	Rough sleeping in Westminster	Rough sleeping / hostels / sofa-surfing etc in Westminster	Rough sleeping / hostels / sofa-surfing etc in Westminster
Health need that can be addressed / improved in an 8 week period	Health need that can be addressed / improved in an 8 week period	Would benefit from additional care navigation and health support	Would benefit from additional / assertive support or a new approach to health
Step up / Step down	Step up		
Recourse / Unclear eligibility / NRPF	Recourse / Unclear eligibility / NRPF	Recourse / Unclear eligibility / NRPF	Recourse / Unclear eligibility / NRPF

Additional points

- Please get **CONSENT** from the person to refer them to a health bed
- Please inform them that it is a **TEMPORARY BED SPACE FOR HEALTH REASONS**
- Please discuss with the person that in order to be accepted into a health bed they will need to **agree to work with the health teams** around improving their health and if this is not happening then the bed stay may be ended
- Please note that the bed stay is a **MAXIMUM of 8 weeks** but **may be shorter** if the person does not require it for the full time

Bed allocation criteria / decision tool

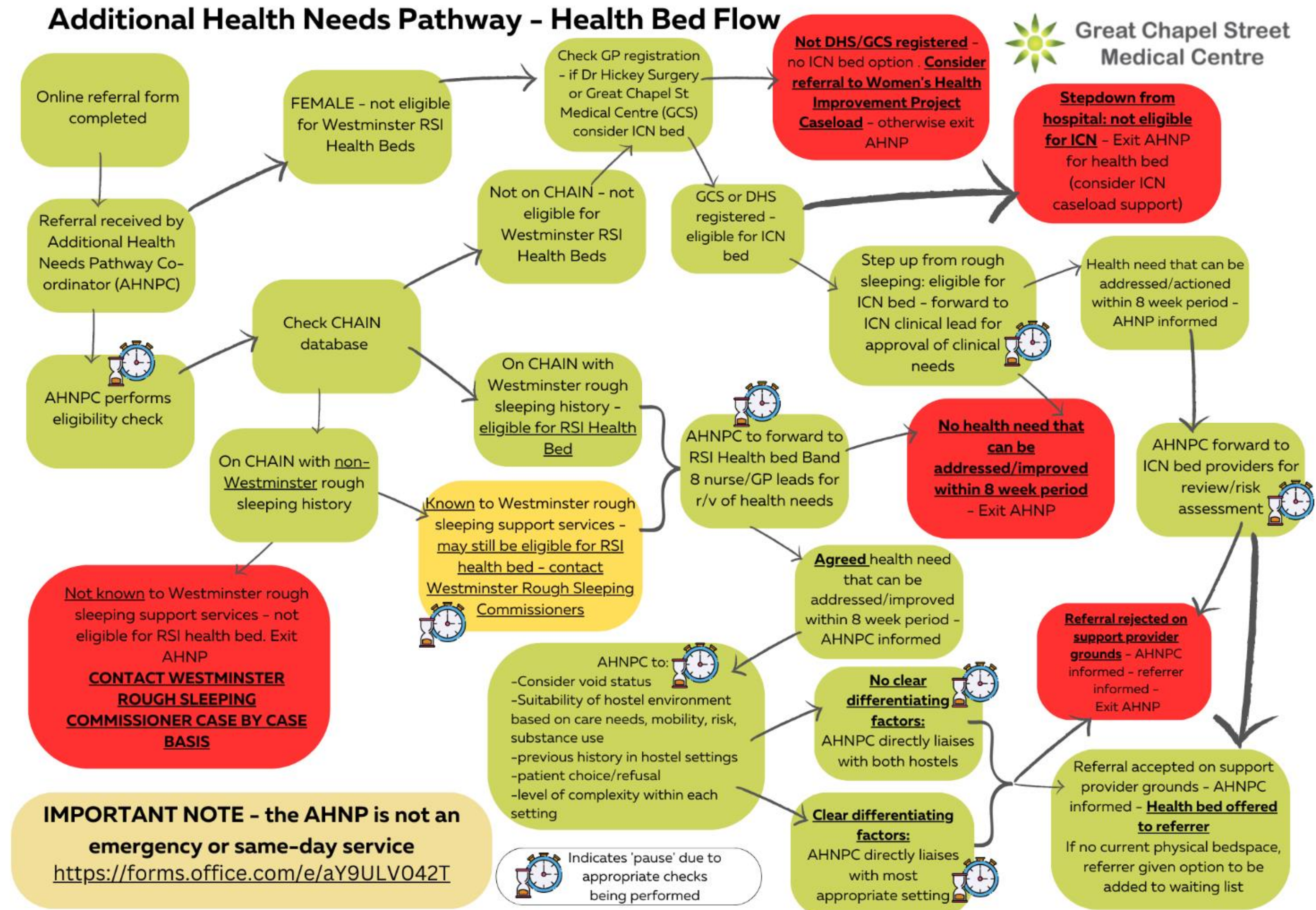
- Decisions will be made by the relevant teams based on:
 - Availability of bed spaces/voids
 - Criteria as previously listed
 - Suitability of placement / environment based on age, care needs, mobility, risk, substance and alcohol use
 - Patient preference
 - Previous history in hostel settings
 - Level of complexity already in each setting

Where no clear differentiating factors – direct liaison with both hostels together will occur.

How to speed up decision / streamline allocation of bed

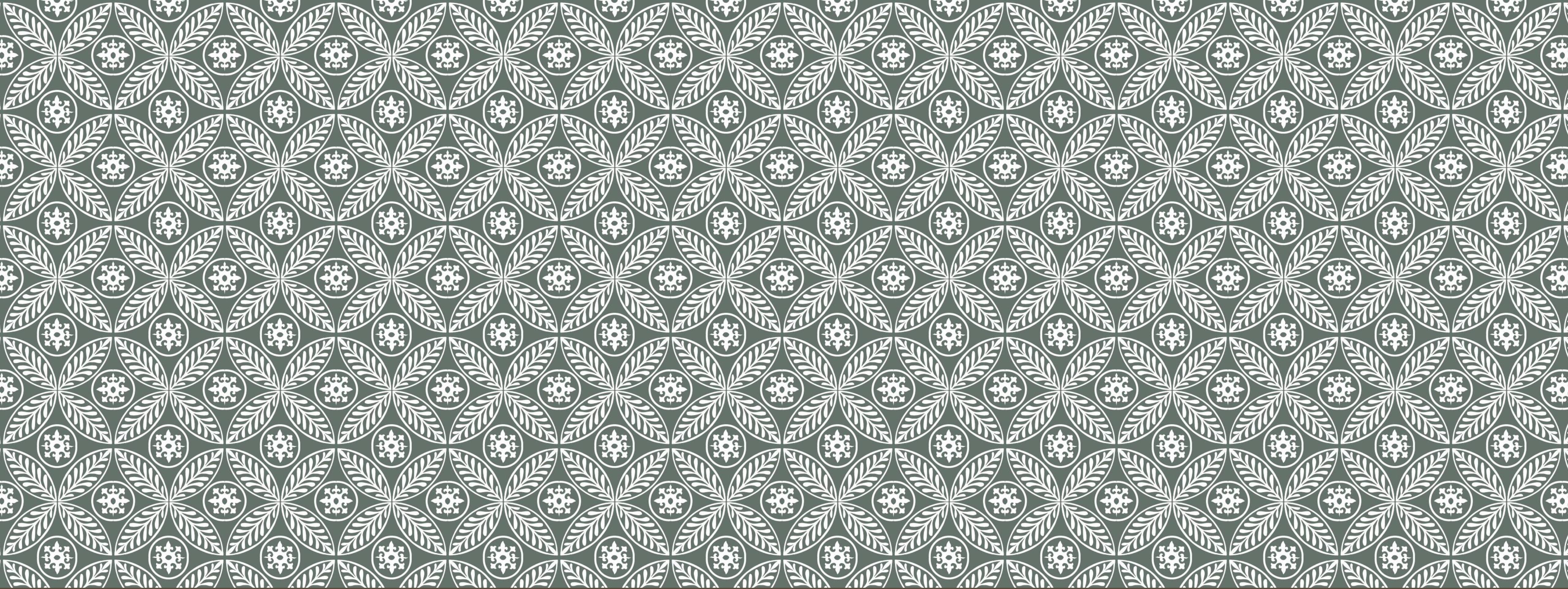
- Ensure **risk history** fully documented as far as known
- Ensure **health needs are clear** and as detailed as possible
- Ideally a **draft discharge summary** if step-down referral
- Ensure **clear mobility and care needs** described as far as known
- Ensure criteria are fulfilled
- Referral is for **health needs** NOT for accommodation
- **Move-on plan** exists
- Previous **history of hostel placement** explored esp if excluded or patient strong preference

AHNP – the flow!



Referral form link

- <https://forms.office.com/e/aY9ULV042T>



WOMEN'S HEALTH IMPROVEMENT PROJECT

Maggie Fielder — Women's health
clinical lead

Ebony Doherty — Women's care
navigator

CRITERIA

Female

Homeless in Westminster – rough sleeping/sofa-surfing/hostels

Will need to consent to be registered temporarily at GCS – will not take away from main GP (Ebony will do that at first contact)

Pregnancy/suspected pregnancy

Concerns regarding specific health condition that requires extra support or health worries that are yet to be investigated and confirmed

Health screening – smears/mammograms/bowel screening/sexual health

Needs GP registration or support with appointments

REFERRAL

All services can refer – e.g outreach/hostels/homeless health/GPs/Hospitals/Substance misuse and alcohol teams etc.

Referrals will need to have a specific goal in mind and this will need to be stated on the referral form.

All additional support needs referral via same form.

No set time on caseload – will be determined by Nurse and Care navigator

Will not hold a waiting list but will accept re referrals if caseload is currently full

CONTACT DETAILS

Great Chapel Street Medical centre –
02074379360

Ebony – 07395318863

Maggie – 07387778452

DR LILY KRAUSE

HOMELESS NEUROPSYCHOLOGY PATHWAY (HNP) - WESTMINSTER PSYCHOLOGY IN HOSTELS (PIH) TEAM

LITZA.KRAUSE@SLAM.NHS.UK, ZANA.KHAN@SLAM.NHS.UK, JESSICA.
BARTON@SLAM.NHS.UK & JUSTYNA.KUBOWICZ@SLAM.NHS.UK

ABOUT THE SERVICE

- The HNP is a pathway within the PiH service
- **High numbers of people who are homeless experience/have experienced brain injuries**
- Damage to the brain can cause significant consequences on a **person's ability to function, their health and socio-economic outcomes**
- One large contributory factor to these difficulties are **changes in cognition** or “thinking skills”.
- Cognitive difficulties may be accentuated by high rates of other comorbid physical, mental health and substance misuse issues commonly seen within this population.

SERVICE OFFER

Aim to support clients who are:

- **Homeless and/or open to homelessness services** (this would include those in hostels or other forms of temporary accommodation)
- AND have a **diagnosed or suspected brain injury**
- AND are **not able to access support through other neuropsychological specific services.**
- The will also include the staff who work with them.

Vision: The aim of the HNP is to address the unmet neuropsychological needs for individuals experiencing homelessness and brain injury and to improve their outcomes.

STAFFING

- 1.0 WTE Band 8A Highly Specialist Clinical Psychologist/Neuropsychologist – NHP Operational Lead.
 - 0.2 Harrow Road
 - 0.2 Neuro pathway specific delivery and leadership
 - 0.4 Joint Homelessness Team (offering specialist psychological and neuropsychological assessment and treatment).
- 0.4 WTE Band 7 Specialist Clinical Psychologists
- 0.2 WTE Homeless Neuro GP Specialist

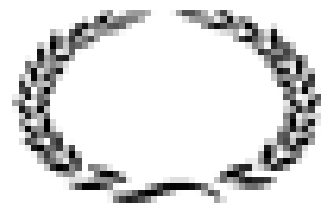
WHAT WE OFFER

- Specialist neuropsychological assessment
- Specialist neuro GP assessment and interventions
- Recommendations and cognitive rehabilitation
- Support or advice around mental capacity assessments
- In relation to brain injury:
 - Support for family and friends
 - Consultation for services
 - Education and training
 - Support or advice to refer to other services

N.B. We are not able to make diagnoses.

EXAMPLES OF WHY SOMEONE MAY BE SEEN IN OUR SERVICE

- The **client presents with cognitive difficulties** (thinking skills) (e.g., slowed thinking, difficulties concentrating, walking into things, difficulties expressing or understanding words, memory problems, difficulty problem solving, planning or inhibiting their responses, getting stuck on their ideas)
- The client presents with **cognitive impairments that have got worse.**
- The client and the system would benefit from **understanding changes in cognition**
 - and help with **implementing strategies** to support them
- The client needs a **capacity assessment**, and you are concerned that existing services may need help to complete the assessment



INVESTOR IN PEOPLE



City of Westminster

STEP (Statutory Team Enabling Pathways) Service

Central and North-West London NHS Foundation Trust

Referral process is to have a pre-referral discussion with a step duty worker before completing the full referral form, do contact: cnwl.step@nhs.net



Central and
North West London
NHS Foundation Trust

TURNING
POINT



daws

Turning Point Drug and Alcohol Wellbeing Service

Westminster, Kensington & Chelsea and
Hammersmith & Fulham

**Meli Stanley – Health Promotion and
Marketing Manager**

**Leon Nicholson – Deputy Operations Manager
DAWS Plus**



Who are we?

- Holistic integrated person centred care
- Strength-based wellbeing approach
- Embedded in the community working with several partners and community groups

Our DAWS plus outreach offer

- Rapid prescribing and treatment for people who are rough sleeping with complex needs
- Presence and support in hostels and on the street
- Criminal justice support in prisons, court and probation

Our clinical offer

- Opiate substitute medicines (OSR)
- Blood borne virus testing, HEP B vaccinations, HEP C anti-viral treatment
- Access to in patient detox and rehabilitation
- Needle exchange and Naloxone
- Fibroid scanning

Our psychosocial offer

- 1-1 support with allocated key worker
- Evidence based group work
- Support and funding around Education, Training and Employment
- Access to peer mentors who act as visible examples of recovery
- Family and carer support groups

Our community offer

- Roads to Wellbeing digital asset map
- Fitness and outdoors activities
- Big ideas fund to support people to make change in the community
- Women's Groups
- Post treatment support

What do our clients think?



From hostel to semi independent living **Written by one of our complex needs navigators**

A young single man who had been in the country since the age of 19 fleeing persecution. Having made contact with him via phone we soon built up a rapport despite him drinking a litre of vodka daily and being very depressed.

A year passed with little contact and we bumped into each other at a hostel and agreed to meet on a weekly basis for a coffee and a walk. Harm minimisation was constantly discussed as he was very naïve of the impact and repercussions of excessive alcohol use. After opening up about his past and having a psychiatrist to talk to he was diagnosed with PTSD. He had turned to alcohol to block out the night terrors. He struggled to fit in at the hostel and was often the victim of racial slurs. He moved around hostels a bit before he felt confident to go to detox. I took him to view a couple of rehabs as this was a large part of his anxiety. We dispelled a few of the barriers and he felt more prepared to take the leap.

He was then housed in a flat but with someone who was still actively drinking and was not appropriate. This was clearly not an environment that would support someone who had just left a rehab. After more perseverance I managed to secure an independent flat. The client had continued to do well and remain abstinent here with the help of our Employment, Training and Education team and a gardening course they had found for him.

Any questions?


- **Email:** daws@turning-point.co.uk
- For clinical advice email us and ask for Dr Al Saidi

[Facebook @LondonDAWS](#)

[Instagram @London.DAWS](#)

[Twitter @LondonDAWS](#)

[DAWS Learning Events |
Eventbrite](#)



Westminster SHP – Assertive Outreach Team



**preventing homelessness
transforming lives**

Aims and Objectives

Aim: To support clients placed in Out of Borough Temporary Accommodation placements, who have a primary support need regarding substance use, to sustain their tenancy and improve engagement in treatment services

Why: It has been identified that this cohort of clients struggle to sustain their tenancy and address their needs when placed out of borough as support provisions are often reduced or become withdrawn – placements often break down and there is an increased likelihood that the person will become street/hidden homeless.

How: A dedicated team will sit within the wider floating support team. It will comprise of 5 Assertive Outreach Workers, 1 Team Manager and 1 p/t Therapist.

The Frontline workers will be assigned a smaller caseload than a standard Floating Support Worker (up to 15 clients per worker over the year) and will follow an assertive outreach method of support. The smaller caseload will enable the team to provide Intensive, responsive, timely and trauma informed support. Effectively meeting the client where they're at in both a physical and mental sense. The smaller case loads also help manage the geographical challenge of out of borough placements

We will work collaboratively with services involved to ensure wrap around support is offered, as well as working with agencies across 32 boroughs to ensure the clients can access the support they need. This will be inclusive of GP service, Community Mental Health Teams and Substance Use Services.

Why Assertive Outreach?

In a Nutshell: Because it works.

How?

The service will take on the responsibility to meet the client where they're at, rather than the client being expected to meet the services needs and requirements for engagement.

We will work, collaboratively and persistently, to build on the motivation for change and support to build better links with services through advocacy. This helps other services show flexibility and consideration for challenges the client may be facing.

We also won't close the case if the client doesn't attend a meeting(S), we will just try again and also try different locations that the client is likely to be at – we will get to know the client and their patterns to help improve engagement opportunities

We will take a holistic approach to ensure the client is supported as a 'whole person' rather than focusing on the one or two major support needs; support plans and goal setting will be done collaboratively to ensure the client's voice is heard and they can set their goals and aspirations which creates greater buy-in.

Where will referrals come from?

Referrals will be sourced via Westminster Housing, Turning Point and other appropriate agencies identified via the strategic group

Work will commence with the client once referral has been accepted by Westminster SHP and in agreement with partner agencies

Any questions – please contact Karen Green – kgreen@shp.org.uk or John Nix – jnix@shp.org.uk

Providing speech and language therapy to people experiencing homelessness and the organisations that support them.

Casework
Training
Advice

**Change
Communication**



Leigh Andrews

Speech and Language Therapist (SLT)

Registered Intermediary for the Ministry of Justice

Honorary Lecturer, School of Health and Psychological Sciences, City, University of London





Communication

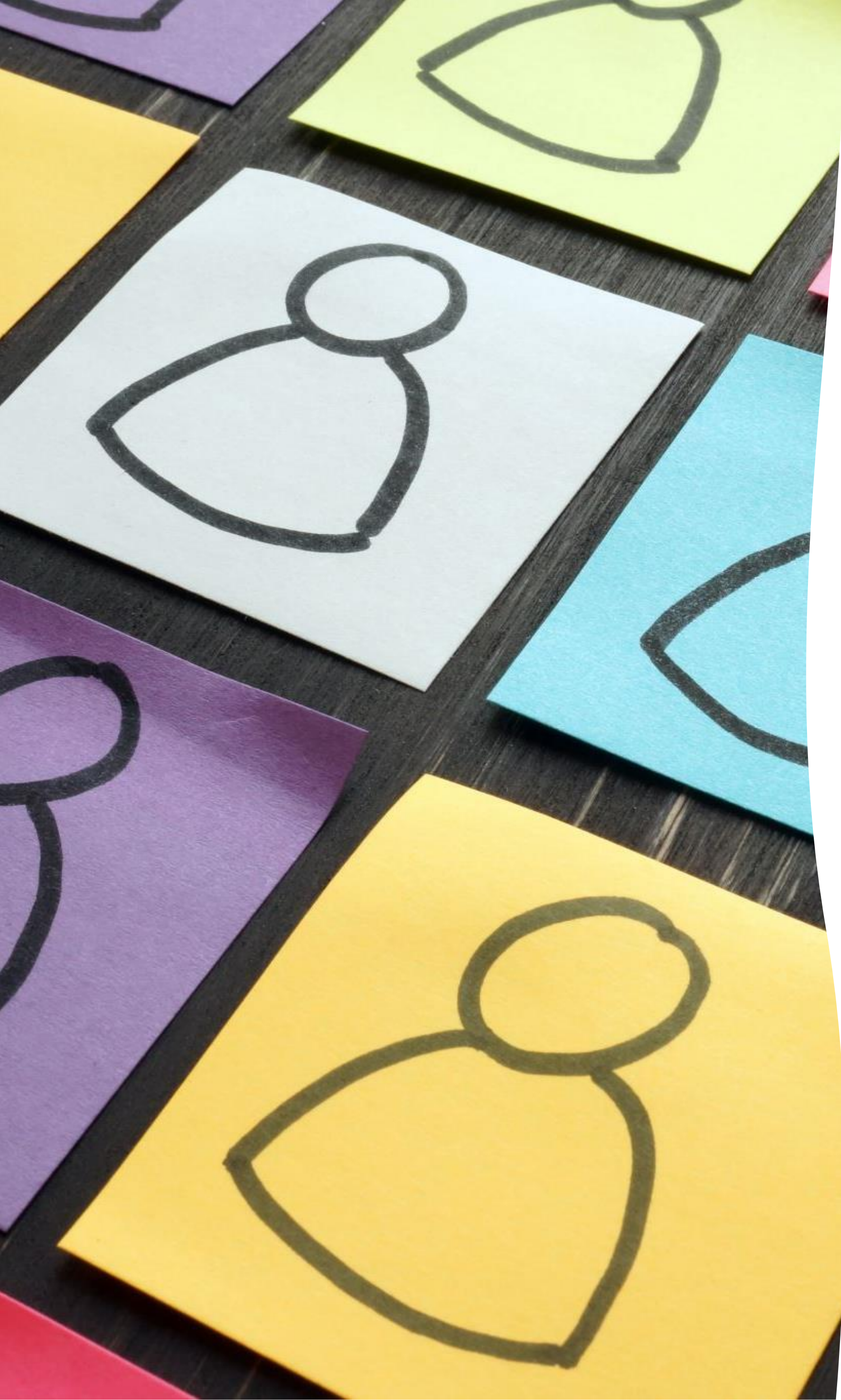
It's not just talking!

- You verbally communicate on the phone, face to face at reception, meetings and appointments .
- You use emails, forms, letters, and documents which require reading and writing skills.
- We ask people to remember their story and tell it to us verbally.
- We give people instructions to follow, e.g. directions, medication regimes.
- We expect people to communicate in complex emotional states and when in pain.
- We use a range of abstract concepts e.g. time, numbers, mental health.

Free webinar for homelessness sector by 4 SLTs:

[Understanding the speech, language & communication needs of people who are experiencing homelessness | Homeless Link](#)





Communication and early emotional trauma

Children's traumatic experiences can affect the way communication skills develop.

Children's traumatic experiences can affect the way they use communication.

Children grow up and become adults.

These communication patterns do not change without support / help / treatment.

Conditions with impact on communication

- Acquired brain injury
- Learning disability
- Autism
- Attention Deficit Hyperactivity Disorder
- Cerebral Palsy
- Deafness
- Mental health difficulties or illness
- Dementias
- Respiratory conditions inc COPD, COVID-19
- Poor dental health
- Stroke

Good to see you
again.



You asked for a short meeting.





Eating and drinking



Contact details

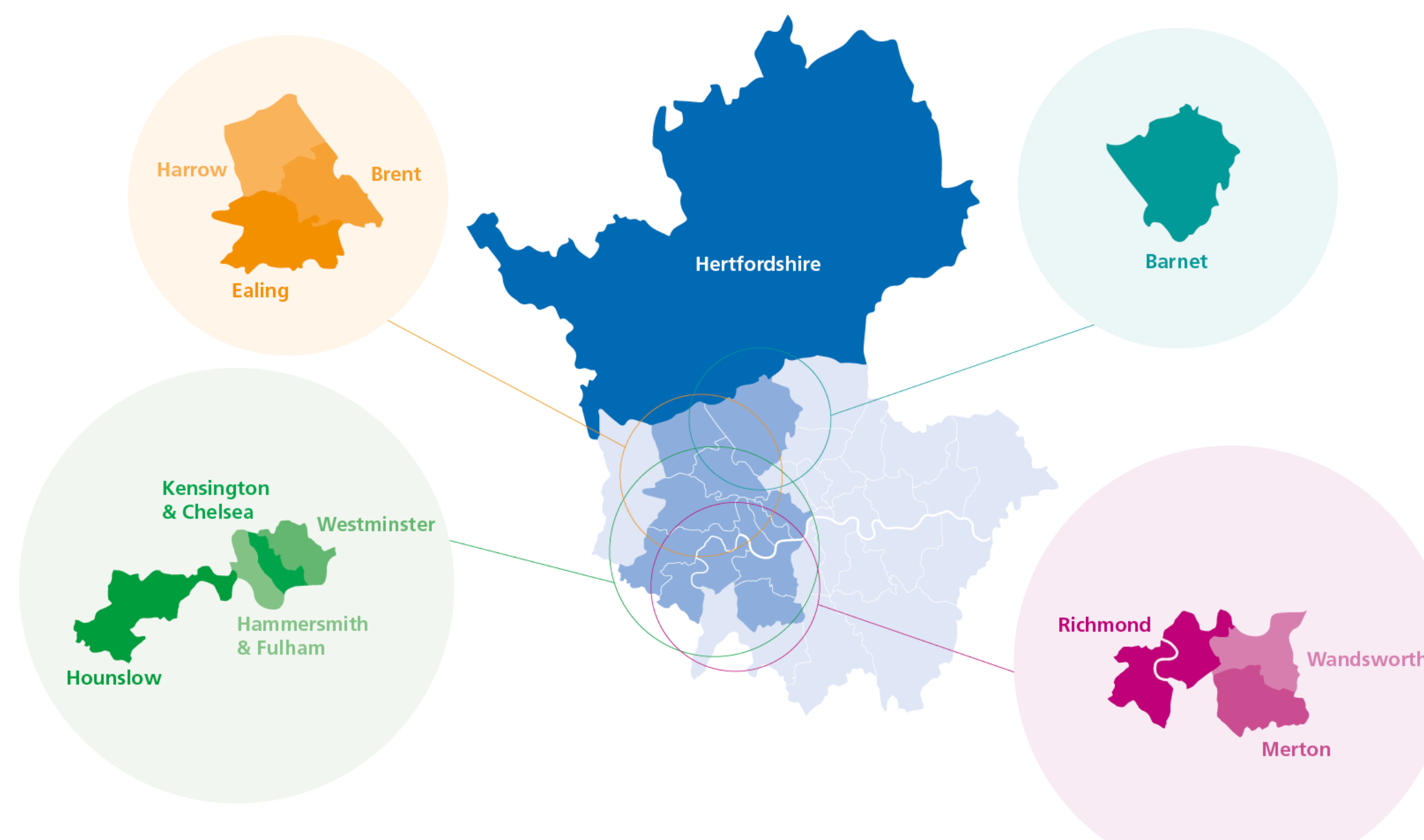
- leigh.andrews@chgcomm.org
- 07957 164 619
- www.chgcomm.org
- @ChgCommC



Central London
Community Healthcare
NHS Trust

Westminster Homeless Health Team Severe and Multiple Disadvantage (SMD) Team

Sharon Stephens
Moya Forsythe
12/05/23

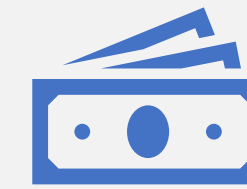


Central London Community Healthcare

NHS Trust



Two Band 7 Nurses, Sharon Stephens,
Moya Forsythe



Funded by RSI, PHE



Work with Rough Sleepers, Temporary
Accommodation, Hostel, Housed (
experiencing SMD)



2 Years project- March 2025

WHY?

Gap identified-

- Hard to reach/hard to engage falling through net

AIMS

- To improve health outcomes
- Reduce LAS callouts
- Reduce unplanned A+E attendances
- Engage with existing services

Overall aim

- **TO IMPROVE WELLBEING**



How?

Referral received

- **Stage 1**

Initial Multiparter Case Conference/Hospital Visit= SMD nurse evaluate if meets criteria?

Either

Accept (Stage 2)

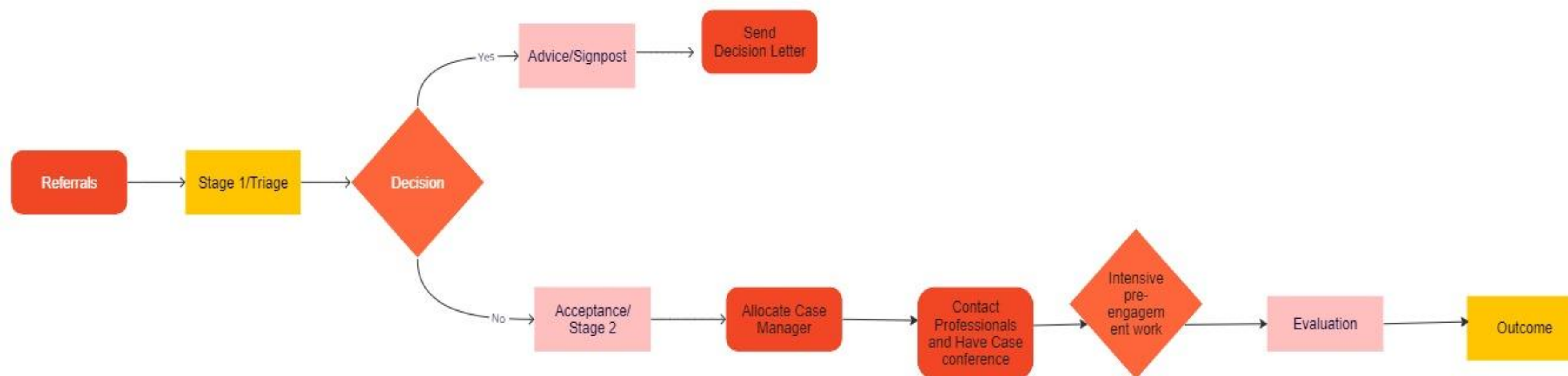
Reject with signposting/recommendation

- **Stage 2**

- **Intensive** work with Key worker/Out reach

- Evaluate after x 3 months





APPROACH

- Whole person Trauma Informed Approach
 - Meet the person where they are at
- Work at pace suitable to person
- Flexibility
 - Plan and co-ordinate
 - In reach alongside MDT
 - Intensive Case Management



Criteria

Inclusion

- SMD – At risk of avoidable harm through unmet health need
- LB Westminster (including borders)
- Case by case assessment of OOB placed by Westminster

Exclusion

- Primary Mental Health/Self neglect
- Chronic disease management
- OOB with no Westminster connection
- Under 18



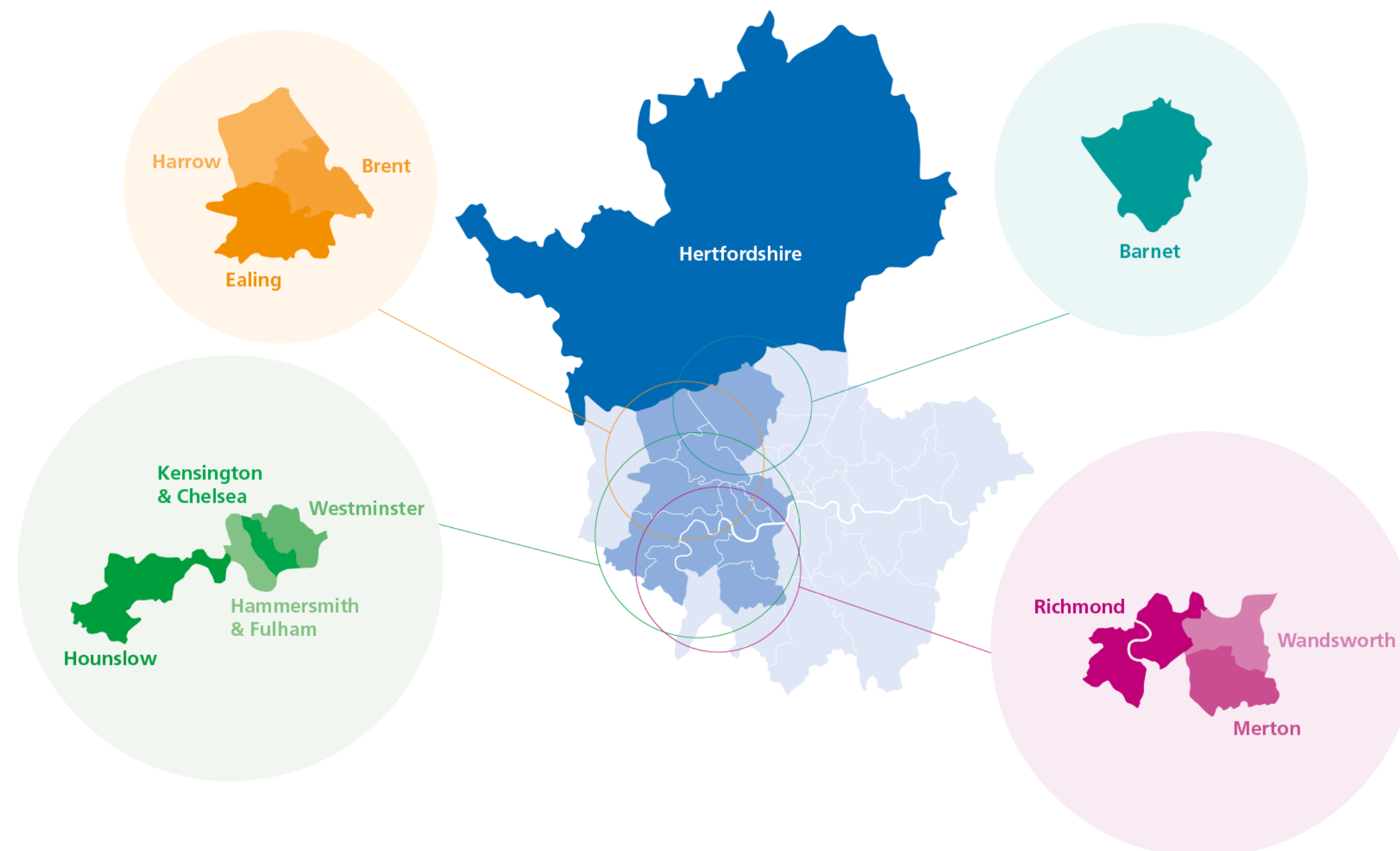
- **Referrals to**
- Clcht.homeless@nhs.net
- **Contacts**
- Sharon Stephens-
Sharon.stephens1@nhs.net
- 07443299885
- Moya Forsythe
M.Forsythe@nhs.net
- 07769913835
- We request referrals have been or **will** be discussed at monthly EVF



Harrow Rd & MORS

Homeless Health clinics

Presenter: Christopher



HRAC

- 2 drop in clinics per week (Mon afternoon and Thurs morning).
- Referrals from hostel staff, GP's , Outreach teams.
- Chronic disease management, minor illness and minor injuries.
- No complex case management due to short stay.

MORS

- Complex case management.
- Max 15 patients on caseload.
- Currently 12 patients on my caseload.
- Minor illness and minor injuries.
- Chronic disease management.
- PIE model currently used (complex case formulations)

MORS continued

- Monthly caseload reviews (Mors management, nurse practitioner, psychotherapist, keyworkers).
- Pabrinex clinics weekly. Working closely with Dr Broyd at DHS. Referrals from DHS and MORS.
- Drop in clinics, Mon mornings and Thursday afternoon.
- Wednesdays complex case management day, follow ups, referrals , case conferences and reviews.

Edward Alsop Court

- Managed by Look Ahead
- 79-bed hostel in Victoria.
- Men only
- Residents with a history of experiencing homelessness
- Many with complex needs (Trauma, MH, addiction, neglect)
- +Frailty
- Frequent LAS call outs
- Non-engagement with health services

Very committed core staff team at EAC, short staffed

Activities worker

Careers (SS+ LA)

In-reach at EAC

- Converted a room into a fully equipped clinical room;

Signed off by MM, infection control, clinical waste, full clinical assessments

- 1 x RGN band 7 (named nurse) 3 days/ week- 67 beds
- 1 Drop- in clinic x ½ day/ week- all residents
- 1 x GP clinic x ½ day/ week- DHS

Wider MDT

- Psychology in hostels- 1 psychologist
- Community palliative care team, occupational therapist, Social worker, Turning Point, CGL
- Podiatrist
- 10 health beds (GCST, 1x b8 + 1x b5)
- 2 ICN beds

Outcomes

- Started a Pabrinex project (22 residents- total 91 injections)
- Increased number of MDT's
- Increased number of residents with POC
- 100% is registered with a GP
- Engagement with health
Health reviews (blood work, nutrition, obs etc) new diagnosis + initiated treatment (infections, infestations, HTN, T2DM, H-pylori, hypercholesterolemia, leg oedema)
- Health days, In reach + Groundswell