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| **Women’s Health Bed Pathway** | Referrals via  [forms.office.com/e/aY9ULV042T](file:///C:\Users\AnnaMidgley\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\KPSU659R\forms.office.com\e\aY9ULV042T) |
| **About the service:**  5 Health Beds are provided at the Marylebone Project in collaboration with Great Chapel Street.  These provide 8 week stays for women with physical health issues who may be homeless when leaving hospital or currently sleeping rough and needing safe and secure space to focus on their health needs.  The Health Beds consist of 5 single bedrooms, one for a resident with no recourse to public funds (NRPF). There are shared kitchens and bathrooms. 4 of the rooms are on the ground floor, and one is on the first floor, which is accessible by a lift.  We do not provide meals, but each resident has their own cooking facilities as well as access to donations. We provide all cooking utensils. The service charge is £15 a week. Our visitor’s policy is that only female guests can visit between the hours of 10:00am and 20:00pm. All visitors must present ID and sign in at reception.  The Marylebone Project benefits from in-reach from CGL, Turning Point as well as on site EET support and creative groups. | |
| **Client criteria:**  Women over the age of 18. They must have a physical health issue that would benefit from intervention and likely to improve over 8 weeks  Clients must be rough sleeping in Westminster (ideally CHAIN verified but case-by-case consideration for non-CHAIN)  Referrers must get consent from the person to refer them to a health bed, understanding that working with the health team is a condition of their stay.  Clients must agree to temporarily register with Great Chapel Street during the course of their stay in the health beds. | |
| **Referral Process**  Referrals are sent via the link above and is then triaged by the Additional Health Needs Pathways Co-ordinator and then assessed for clinical suitability by the team at Great Chapel Street. It is then passed to The Marylebone Project where an assessment is arranged.  The aim is for this to be done within 36 hours, and to make this process as streamlined as possible it is requested that on the referral form there is:   * Full risk history * Clear and detailed health needs * Clear mobility and care needs * An existing move on plan * Previous history of hostel placements, even if excluded * A draft discharge summary (if a step down from hospital) | |
| **Support:**  The Homeless Health Advanced Nurse Practitioner attends the project twice a week. Their role is:   * Health assessment and care plan * Health treatment and advice * Prescriptions * Vaccinations * Wound care * Referrals to other health services   The Health Navigator is on site Monday-Friday 9-5pm. Their role is:   * Day to day support * Support planning * Empowering the resident to self-manage * Signposting to agencies for holistic support * Support with groups and activities   There are weekly meetings with the wider team at TMP and GCS including input from a GP. | |
| **Expectations of client:**  Residents are involved in their support planning with the Health Navigator and it is expected that this is reviewed weekly. It is expected that they see the Nurse weekly also on her visits to the hostel. | |
| **Move-on pathway expectations:**  All residents will be expected to engage with identified support to enable them to successfully move out of The Marylebone Project successfully, and not return to the streets. Though move on accommodation is looked for, this cannot always be guaranteed. It is the role of the referrer to work with the Health Navigator to look for suitable move on accommodation. | |