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**Evaluation of the Homeless
Palliative Care Service at St Ann's
Hospice for the Big Lottery Fund
October 2024**

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“ A Better Ending -
Getting it Right at the End of Life for People
Experiencing Homelessness. ”

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Executive summary and key messages

Homelessness has a devastating impact on health outcomes and is directly linked to tri- morbidity, complex health needs and premature death.

St Ann's Homeless Palliative Care Service was established to support people experiencing homelessness with advanced ill health, using a trauma-informed and evidence-based approach to the delivery of care. The scoping project was commissioned to identify the 'best fit' approach to support this patient cohort, with the flexibility to evolve in response to changing needs, utilising innovative ways of working across Greater Manchester.

The Homeless Palliative Care Service has provided care co-ordination for approximately 145 patients. Multi-disciplinary teams meetings have been held for 71% of patients referred into the service. Weekly in-reach support has been introduced to two complex needs hostels and community outreach provided 0.5 days per week with a Consultant in Palliative Medicine. Partnership working with Inpatient Palliative Care team at the Manchester Royal Infirmary includes weekly ward rounds. Training and education sessions delivered to over 2,000 health and homeless professionals across Greater Manchester and the UK, improving earlier identification of people experiencing homelessness with deteriorating health and improving the knowledge and confidence of frontline staff.

Challenges that the project faced included the COVID-19 pandemic during the first two years. In 2020 the service received a Special Recognition Award from the High Sheriff of Greater Manchester to acknowledge the work that continued throughout the coronavirus pandemic. Later in 2021, The Mayor of Greater Manchester, Andy Burnham, also presented the 'Mayor's Award' to the Homeless Palliative Care Service at the Greater Manchester Health and Care Champion Awards.

To date, the project has provided case management; facilitated multiple admissions to St Ann's Hospice for specialist end of life care; delivered education and training to over 2,000 cross sector professionals; provided support to hostel staff and residents via weekly in-reach; and provided consultant outreach that increased both the number and speed of referrals. Ongoing feedback, a stakeholder survey and interviews revealed that the participants highlighted that multi-disciplinary working results in better outcomes for patients and staff alike. The



choice and control offered by the coordinators and front line staff is a key ingredient for building trust and ensuring positive outcomes for patients. Several case studies illustrate the effectiveness and impact of the service.

The project cost £339,000 over five years. Over five years, the St Ann's Homeless Palliative Care Service 'scoping project' has been very good value for money. It has excellent alignment with both the NHS England's Action on Inclusion Health Framework and the NICE Guidelines [NG214] Integrated health and social care for people experiencing homelessness.

The St Ann's Homeless Palliative Care Service has improved access and equity of palliative care to people experiencing homelessness across Greater Manchester. Projects such as the Homelessness Palliative Care Service are not a 'toolkit' to be adopted but demonstrate a culture to be developed and scaled-up across the ten boroughs of Greater Manchester. The culture change is to accept people for who they are, where they are, and support them without judgment, since everyone deserves to die with dignity. The evidence-based work within third-sector organisations such as St Ann's Hospice are vital in transforming both research into practice, and practice into research.

Introduction to the Homeless Palliative Care Service

This report is the final evaluation of the Homeless Palliative Care Service that has been delivered by St Ann's Hospice. In 2019, St Ann's Hospice secured a five-year grant from the Big Lottery Funds 'Reaching Communities Programme' to develop and deliver a Homeless Palliative Care Service across Greater Manchester. The North West had the second highest recorded homeless deaths in the country in 2022/2023 with the highest number in Greater Manchester. People experiencing homelessness often have poor health linked to multiple disadvantages.

St Ann's Homeless Palliative Care Service aimed to change how they and other organisations work with people experiencing homelessness who have advanced ill health,

giving them a better quality of life, and ensuring they receive equitable access to care and support as their health deteriorates. Since February 2020, the service has given vulnerable people the opportunity to choose their treatment, the chance to reconnect with loved ones, and the possibility to die in a dignified, comfortable way in a place of their choosing. The Homelessness Palliative Care Service **is an evidence-based model of care for people experiencing multiple disadvantage**¹.

Health, Multiple Disadvantage and Homelessness

Homelessness

The causes and consequences of homelessness are complex. Homelessness can happen to anyone, but some people are more likely to experience it than others, e.g. those living in poverty or who have experienced childhood trauma. There are individual and structural routes into homelessness. Whatever the reason, those experience homelessness often have multiple challenges like poor mental and physical health, substance use issues, social isolation, unstable family relationships and trauma .

Everyone has the right to receive the care and support they need. But for many people affected by homelessness, who need support for cancer or other life-limiting illnesses, it can be incredibly difficult to access especially if their health is getting worse, or they're nearing the end of their life. This can also be challenging and distressing for the professionals who work with them as deaths can be unplanned and access to palliative care is very unusual. The national landscape for inclusion health and homelessness shows that:

- Homelessness is an independent risk factor for premature mortality and is associated with extremes of deprivation and multiple morbidity
- Mortality rates in people experiencing homelessness are eight times higher for women and 12 times higher for men, for all causes of death
- Average age of death is 43 compared to 81 years for women
- Average age of death is 46 compared to 76 years for men
- Deaths of people experiencing homelessness are often unplanned and undignified with little access to palliative care^{5,6}.

Health Inequalities

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. These include how long people live, the health conditions they experience and available care. Therefore, some groups are more likely to experience poorer health than the general population⁷. Research has shown that people experiencing homelessness are dying young and in unsupported, unacceptable situations. Many have a complex combination of physical health, mental health and substance misuse issues with a high prevalence of trauma including adverse childhood experiences⁹. Research has been conducted examining a wide range of issues in relation to end of life care for homeless people and a review of the literature concluded that service providers need to offer needs-based and non-judgemental care, co-producing services, addressing gaps and transforming existing knowledge into action^{10, 11, 12}.

Rationale for HPCS and Inclusion Health Services

The Homelessness Palliative Care Service follows the evolving evidence-based model of care for people experiencing multiple disadvantage. In 2022, NICE published their Guidelines [NG214] Integrated health and social care for people experiencing homelessness³ above³. NICE worked with the Centre for Homelessness Impact on this guideline. The challenges and barriers to accessing palliative care for people affected by homelessness and potential strategies for improving care and support have been studied as part of the Healthy London Partnership between, University College London (UCL) in collaboration with the Marie Curie Palliative Care Research Department (UCL) and the homeless charities Pathway and St Mungo's¹³. They recommended and developed the London Pathway, a model of integrated healthcare for single homeless people and rough sleepers, embedding multidisciplinary, person centred care and support for people with advanced ill health, by bringing together palliative care and multidisciplinary support, including into homeless hostels¹⁴. In addition they have created a research informed 'Homeless Palliative Care Toolkit' for frontline staff and a set of 'Homeless and Inclusion Health Standards for Commissioners and Service Providers'¹⁶.

Strategic Context

Across Greater Manchester, close partnerships between healthcare providers and the commissioner are encouraging integrated working for understanding needs and assets of different communities to support improvements in access, experience and outcomes of care¹⁷. Greater Manchester has co-produced a Homelessness Prevention Strategy working in partnership with, amongst others, the Greater Manchester Health and Social Care Partnership and Greater Manchester's 10 local authorities¹⁸.

Nationally, NHS England's Action on Inclusion Health framework focuses on the role that the NHS plays in improving healthcare, and how partnerships across sectors such as housing and the voluntary and community sector play a key role in addressing wider determinants of health¹⁹. The framework is based on five principles for action on inclusion health as shown in Figure 1. Inclusion health groups include **people experiencing homelessness**. The Homeless Palliative Care Service aligns with all five principles.

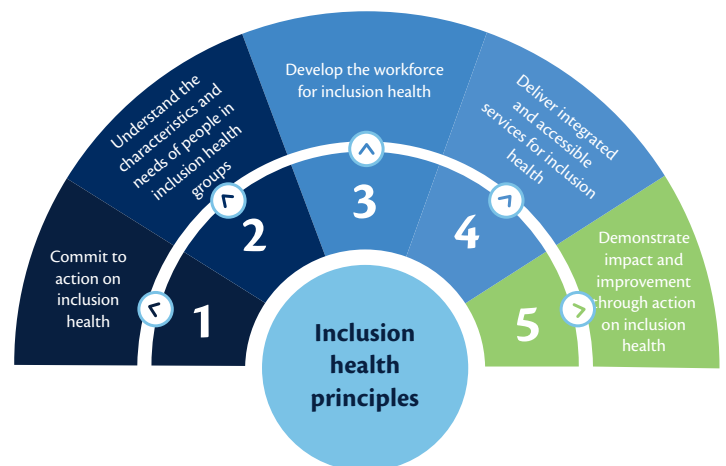


Figure 1. NHS England's Action on Inclusion Health Framework

NHS England have developed the Core20Plus5 approach to support the reduction of healthcare inequalities at a national and system level²⁰. The approach defines a target population the 'Core20PLUS' and identifies '5' clinical areas requiring accelerated improvement.

PLUS population groups incorporate Inclusion health groups, of which people experiencing homelessness are included.

Within Greater Manchester there is a high demand²¹:

- 11,500 people experience homelessness across Greater Manchester²²
- Manchester ranks third-highest in the country with 7,407 people experiencing homelessness (per capita), that is 1 in 74 people²³. A 25% increase from 2022-2023
- Nationally, there were 741 deaths of homeless people in England and Wales of which 17 (2.3%) were in Manchester, and 114 in the North West (15%) in 2021²⁴.
- Manchester opened the highest number homeless applications of any Local Authority in England, 6,525 in 2021-22. An increase of 54% between 2018/19 and 2021/22.

People experiencing homelessness often have poor health. 78% of people experiencing homelessness reported having a physical health condition in 2018-21 and 80% of these having at least one co-morbidity, with 29% having between five and ten diagnoses.

Evolution and delivery of the Homeless Palliative Care Service

The St Ann's Homeless Palliative Care Service was established as a 'scoping project' in January 2020 in order to understand the landscape of homelessness and inclusion health across Greater Manchester, and identify the "best fit" service model that would improve equitable access to

palliative care for people experiencing homelessness and offer tailored interventions across ten Greater Manchester boroughs: Bury, Stockport, Wigan, Tameside, Salford, Bolton, Oldham, Trafford, Rochdale and Manchester (Figure 2).



Figure 2. Geographical footprint of the Homeless Palliative Care Service

The St Ann's Homeless Palliative Care Service currently employs two Homeless Palliative Care Coordinators at 1.4FTE. As many people experiencing homelessness are excluded from mainstream services, they remain in inappropriate care environments as their health deteriorates and they may not get the opportunity to have conversations about coming to the end of their lives. The Homelessness Palliative Care Service gives people

opportunities to talk about their final wishes and offer advice and guidance to the people around them to enable a supported and trusted experience for all involved.

St Ann's Homeless Palliative Care Service aims to change how they and other organisations work with people experiencing homelessness who have advanced ill health. It does this by focusing on four broad outcomes (Figure 3):



Figure 3. Evolving Outcomes for the Homeless Palliative Care Service

The project began in 2020 with one palliative care co-ordinator employed to cover the ten Greater Manchester boroughs with an initial focus on Manchester and Salford. However, just six weeks later, the COVID-19 pandemic resulted in a national lockdown. Therefore, significant adjustments were made, some work went online and the focus became to identify stakeholders and build partnerships (Figure 4).

By Year 3, after the pandemic, face-to-face support, networking and training resumed. The service increased in capacity to two palliative care co-ordinators (1.4FTE) as a job share following maternity leave. A hostel in-reach programme was developed alongside staff training. By Year 4 the two co-ordinators had established regular

weekly/fortnightly participation in multidisciplinary teams to support patients under two inclusion health GP practices in Greater Manchester, and developed new more flexible ways of working including 'in reach' into hostels, and the Manchester Royal Infirmary.

In Year 5 relationships with inpatient palliative care teams were further strengthened and a Consultant in Palliative Medicine was added to the team one morning a week, strengthening community outreach. In response to an increase in admissions of homeless patients to the hospice, the coordinators developed and implemented a homeless awareness campaign to support culture change whilst increasing knowledge and confidence across the workforce.

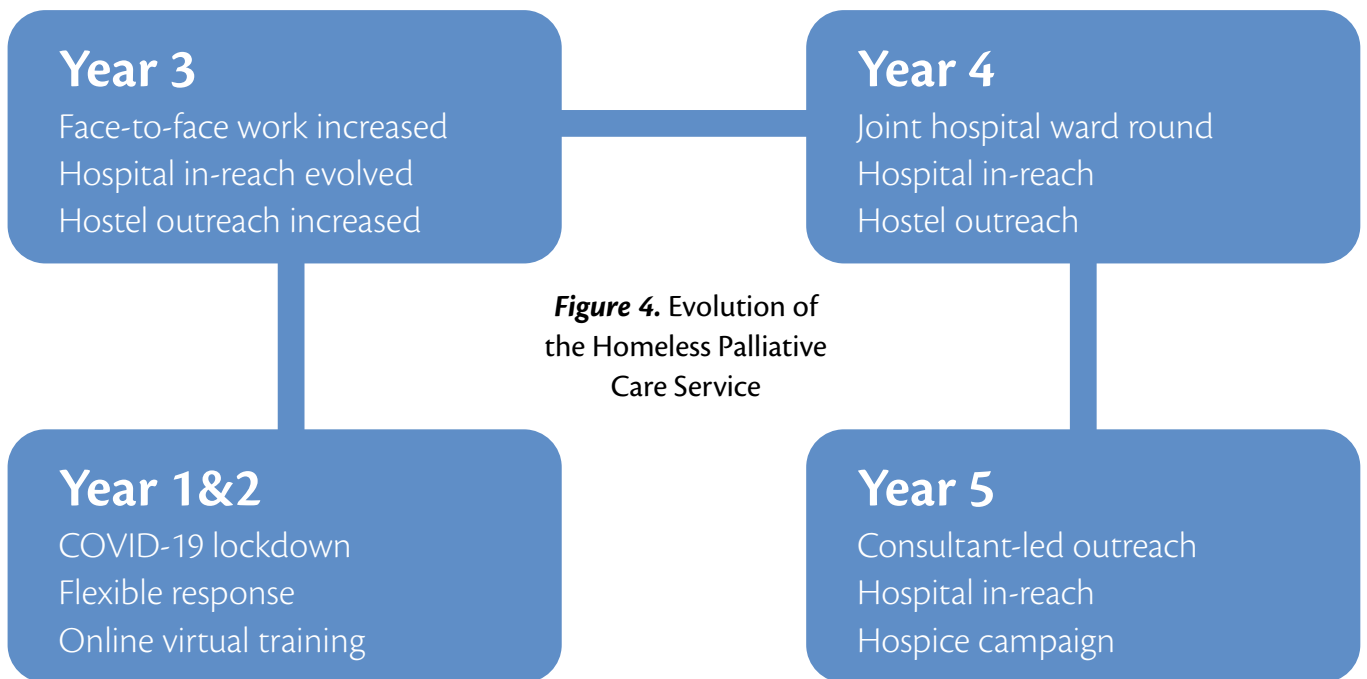


Figure 4. Evolution of the Homeless Palliative Care Service

The Big Lottery funds projects work to make positive changes in their community (people with similar life experiences) and the nature of the scoping project allowed a flexible approach that adapted over time and reacted to changing circumstances whilst still meeting the four broad outcomes. The 'test and learn' approach without hard targets allowed flexible working and innovation to demonstrate what works in quite a short timeframe. The Homeless Palliative Care Service used a formative approach to evaluation, where evaluation has been ongoing and has fed back into management and planning processes to inform the development of the project as it progressed (Appendix 1). As such it has been a vital management tool because, critically, formative evaluation highlights the

key lessons, achievements and issues as they arise, enabling informed decision-making about the future direction of the project.



St Ann's HPCS in numbers

Care co-ordination for approximately

145

patients across all ten GM boroughs



Training and education sessions delivered to over

2,000



health and homeless professionals across GM and the UK, improving earlier identification of people experiencing homelessness with deteriorating health

Partnership working with Inpatient Palliative Care team at the MRI, including weekly ward rounds



Community outreach

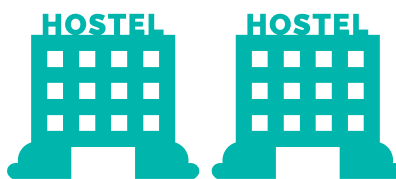
0.5



days per week with a Consultant in Palliative Medicine

Provided weekly in-reach support to

2



complex needs hostels within GM

Multi Disciplinary Teams meetings held for

71%

of patients referred into the service



Contribution to research with Marie Curie and UCL



1.5k Views of Homeless Film

2 Awards



Figure 5. St Ann's HPCS in numbers

Key achievements

This section evaluates the delivery and impact of the Homeless Palliative Care Service scoping project across Greater Manchester over five years. The four broad outcomes were (i) case management, (ii) psychological/emotional support, (iii) education and training and (iv) networks and partnerships (Figure 3). The latter two outcomes have been jointly considered. Feedback from all stakeholders has been collected throughout the project and detailed in the annual reports to the Big lottery Fund. A sample is shown below of stakeholder feedback (Figure 6).

Stakeholder feedback



Figure 6. Stakeholder Feedback

Outcome 1. Case management: Key achievements

What was the issue?

Typical hospice patients are imaged to be older people with cancer and concerned families - not younger people with complex lives, an uncertain prognosis and experiencing homelessness. Often the problems that led to a person becoming homeless also make it harder for them to get help, such as experiencing stigma and discrimination,

a lack of close family and friends for support, and inflexible or poorly organised services. In particular, there can be poor recognition of palliative needs for homeless people resulting in a lack of referral or late referral to appropriate care and health services.

The Homeless Palliative Care Service response

The Homeless Palliative Care Service focused on two solutions:

Referral criteria

If staff had a 'concern' about someone's deteriorating health needing end of life care, this was enough to warrant a referral being made for anyone experiencing homelessness or who are insecurely housed within Greater Manchester. Accepting referrals in the absence of formal diagnosis is in line with NICE good practice guideline (NG214) 'Integrated health and social care for people experiencing homelessness'.

Increasing Access

The Homeless Palliative Care Service increased access by introducing hospital outreach services, hostel in reach services and by training staff (nurses, hostel staff) to identify palliative needs amongst anyone with deteriorating health.

The Homeless Palliative Care Service supported and advocated on behalf of clients to navigate and manage transitions between healthcare services and not fall between gaps.



Case Study - Sonja aged 49.



Sonja was admitted to hospital over Christmas following significant weight loss and repeated vomiting. She received a diagnosis of terminal oesophageal cancer with nine months to live. While in hospital her partner moved another person into the flat she shared with them and told her not to come home, leaving Sonja homeless. Originally from Poland, Sonja does not speak English and has no family or friends who can support her.

She was referred to the local council for housing but found ineligible due to being unemployed (due to COVID redundancy) and being an EA national without settled status. She was found ineligible for support under the Care Act because she could mobilise around the ward herself and was deemed not to have care or support needs.

Sonja was due to be discharged to a homeless hotel where she would have to share a microwave and bathroom facilities. The Palliative Care Coordinator (PCC) was aware that patients often are not offered chemotherapy if living in shared accommodation due to the inability to self isolate and its effect upon immunity. To deny Sonja access to this health care would violate her human rights.

The PCC advocated for appropriate housing under Human Rights Act Legislation and accessed pro bono legal advice. It was through the help of the solicitor and threat of legal action that caused the council to reconsider her case and, thankfully, place her in appropriate accommodation where she could access ongoing treatment safely.

“To deny Sonja access to this health care would violate her human rights.

The Palliative Care Coordinator advocated for appropriate housing under Human Rights Act Legislation and accessed pro bono legal advice to strengthen Sonja’s case.”

While in hospital a Macmillan grant was applied for (£350) as well as PIP benefits but these would take three weeks to be processed, and Sonja was discharged to her accommodation without any food or source of income. The PCC accessed emergency food parcels and hygiene supplies from Mustard Tree and Red Cross, and ensured Sonja would have appropriate food to eat for the coming weeks until her benefits came through.

The PCC is working to find a Polish befriender to support Sonja over the coming weeks and months and will be seeing her weekly to offer supportive care and opportunities to do advance care planning for her end of life.

Inclusion Health Barriers

Logistical Challenges and Service Design, Lack of Empowerment

What was important to Sonja?

- ✓ Appropriate accommodation and access to treatment.
- ✓ Legal advice about her human rights and a translator.

Outcome/Key achievements from case management

The Homeless Palliative Care Service has successfully worked with many individuals supporting them to make informed choices about palliative care, ensuring that their final wishes are respected, and that appropriate care and pain relief arrangements were in place.

The most referrals have been for patients aged between 50-59 with an even split for younger and older people. There has consistently been around seven males for every female supported. The most frequent health diagnosis upon referral is terminal cancer, followed by deteriorating health, renal failure and liver disease. About half of the individuals have such complex needs that multidisciplinary team meetings were held to coordinate care.

Over five years, including the COVID-19 pandemic lockdowns, the Homeless Palliative Care Service has provided case management and support to 145 patients, with 28-33 new referrals per year from across all ten Greater Manchester boroughs. Multidisciplinary team meetings were coordinated for 71% of patients referred to the service. 14 patients have been supported to attend their own case review meetings.

The in-reach in to complex needs hostels in Manchester has delivered 166 interventions and seven additional residents referred to St Ann's hospice in 12 months since June 2023. St Ann's loaned iPads that were used to facilitate 250+ online interventions e.g. virtual homeless assessments, GP registration, benefits support and onward referrals.

Research has shown that reaching people earlier allows more time to build a trusting trauma-informed relationship and advocate for flexible, personalised responsive care pathway²⁵. The current healthcare systems are failing to provide palliative care for people experiencing homelessness. It is not the people with health inequalities who are failing nor are they the problem to be solved. Advocacy by the care coordinators has made inaccessible services accessible, reduced the struggle of being alone and enabled/empowered individuals to navigate complex healthcare systems.

Since 2020, the Homelessness Palliative Care Service has developed, delivered and embedded, appropriate, effective responses from cross sector services, to improve equitable access to palliative and end of life care.



Outcome 2. Psychological/emotional support: Key achievements

What was the issue?

Non-clinical homeless sector staff working with people who are homeless with advanced ill health carry a heavy burden psychologically and practically, and support is needed.

People experiencing homelessness who have advanced ill health often struggle to navigate the complex web of health and care services and feel disempowered as a result. In turn this can be interpreted by professionals ambivalence. The coordinators expressed the view that it is not realistic, to expect someone to change at the end of their life, to fit in to a service or culture they have spent their lives living outside of.

The Homeless Palliative Care Service response

The Homeless Palliative Care Service aimed to support staff, volunteers and those affected by the psychological and emotional aspects of approaching the end of life, including bereavement support.

- For professional staff and volunteers the Homeless Palliative Care Service has provided a wide ranging suite of training and partnership working using good practice to allow clients to receive equitable access to care and support as their health deteriorates from the many staff they interact with (described below).
- For clients, the coordinators focus on building trust by understanding an individual's experience and needs and then are able to guide the clients through the complex web of services. Coordinators validate the patient's own experience by having discussions that are trauma informed about advanced care planning in an appropriate way at any suitable venue.
- For the two Homeless Palliative Care Service coordinators, following trauma-informed principles, monthly clinical supervisions took place. After maternity leave, when the 1FTE role expanded to a 1.4FTE job share, the service was enhanced and the staff felt less isolated.

Outcome/Key achievements from psychological and emotional support

For their clients, the Homeless Palliative Care Service has delivered personalised choice, empowerment and control giving them a better quality of life.



Case Study - John aged 69.



“You’re alright, you lot. You help me get my mind calm about what’s coming. I feel in control and I’ve not had that before.”

John had been intermittently homeless since his marriage broke down 30 years previously. The trauma of losing his family meant John lost control of his life. He ended up on the streets, in and out of hostels and in temporary accommodation. John became unwell, but as with many people experiencing homelessness and rough sleeping, John only went to A & E when he could not take the pain any longer. Upon being admitted he received the news that he had a late-stage liver cancer, with a prognosis of weeks to live.

The Palliative Care Coordinator (PCC) was contacted by the Palliative Care team at MRI hospital and she **facilitated an admission to St Ann’s Hospice** for end of life care. With food, rest and support John started to build back some strength. A **family reconnection** was sensitively facilitated between John and his daughter who he had not had contact with for 14 years. Care was taken by the PCC to also support his daughter given their history and estrangement.

John was moved to a nursing home and the PCC saw John weekly and had conversations about **advance care planning and his future wishes**, what treatment and care he would want at the end of life. He lived for four more months. When John deteriorated, the PCC arranged for John to be brought back to the hospice where he died a few days later. John identified his **Preferred Place of Death** as the hospice as he felt he could trust the PCC and other staff and he felt comfortable there.

John bought gifts for the grandchildren he didn’t know he had, a suit for his own funeral as it was important to him that he look smart and had his **photo** taken, as **he wanted to leave evidence that he existed**. The PCC assured him she would show his photo to people she trains and supports, and to the funders of her role. He was pleased about this.

The PCC relayed John’s **funeral wishes** to his daughter and attended his funeral to support his daughter. The daughter requested **counselling support** through the PCC which was followed up by our counselling service.

Inclusion Health Barriers

Logistical Challenges and Service Design, Lack of Empowerment.

What was important to John?

- ✓ To leave evidence that he existed and share his experiences.
- ✓ To be comfortable and trusted in his Preferred Place of Death.

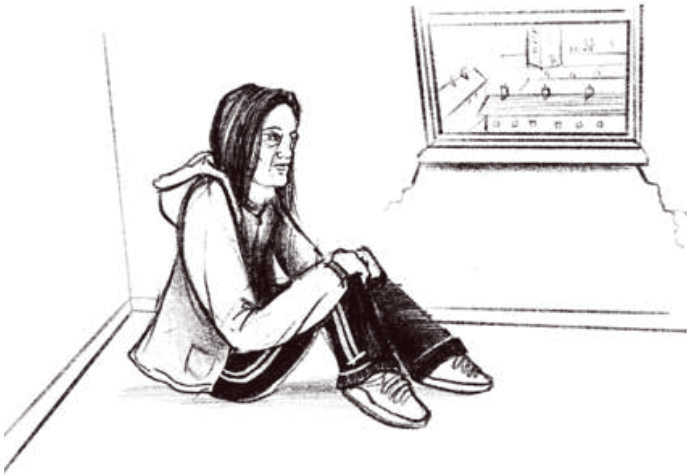
Outcome/Key achievements from case management

Bereavement counselling was increased when the demand for talking therapies increased over the COVID-19 pandemic in Year 1 and 2 supported by an increase in funds specifically to allow for counselling support. The Homeless Palliative Care Service had the flexibility to allow personalised responses such as meeting in person, anywhere comfortable, in a non-clinical environment. The flexible and accessible referral criteria meant that people could access emotional support whilst on a waiting list for more formal statutory intervention.

The Homeless Palliative Care Service was also able to use innovative bespoke approaches relevant to individual needs that met the broad outcomes underpinned by trauma informed principles. The service was not constrained by quantitative metrics, targets and key performance indicators. The case study illustrates the choice, empowerment and control given to clients.



Case Study - Joanna aged 43.



Joanna is a 43-year-old woman with a diagnosis of Amyloidosis, linked to IV drug use and untreated Hepatitis C. She was referred to the Homeless Palliative Care Service in March 2022 by her Substance Misuse Worker, when during an admission to Manchester Royal Infirmary (MRI) the decision was made to commence dialysis.

She has been homeless for 17 years with prolonged periods of rough sleeping, chaotic drug use and self-neglect. She lives in a high needs hostel and feels safe there, injects Heroin and smokes Crack, which began when she was 20. Estranged from family at 14 and describes a childhood involving exposure to trauma from a young age; an older friendship group led to further experiences of trauma as a young adult.

Reason for referral; coordination of care, advocacy, support & advice for professionals and advance care planning. Joanne struggled to engage with dialysis, missing sessions frequently, was unable to maintain Methadone due to poor mobility from extensive leg ulcers and uncontrolled pain. Frequently expressed frustration at receiving inadequate pain relief and how this impacted her ability to engage with support.

Inclusion Health Barriers

Discrimination, Stigmatisation and Disempowerment.

“It’s not the same with you, I feel like I can talk to you and be honest, even about bad stuff like not using drugs - I don’t feel like you’re thinking bad things about me and you don’t lecture me or make me feel small.”

What was important to Joanne?

- ✓ To be listened to and believed.
- ✓ To receive effective pain management.
- ✓ To be treated with dignity, respect and without prejudice.
- ✓ To reconnect with family and meet her niece and nephew.

What did our partners say? Doctor in Palliative Medicine, Hospice

“The Homeless Palliative Care Service were instrumental in coordinating multi-professional meetings to discuss ongoing care needs and facilitate discharge planning. They brought extensive expertise, knowledge and support to discussions which benefitted both the patient and professionals involved.”

ST5 Doctor, MRI.

“The Homeless Palliative Care Service feels unique in its degree of flexibility, cross service working and time and expertise offered. It is evident that the specialist knowledge and skill set they possess, allows them to come up with creative and dynamic solutions for a patient group that requires us to ‘think outside the box’ in order to meet their needs.”

Outcome 3 and 4. Education, Training, Networks and Partnerships: Key achievements

What was the issue?

Generally, health and social care professionals lack knowledge on homelessness and may not feel confident to support people with such complex needs. As a result, people experiencing homelessness can be subjected to negative judgements and stigma, often due to this lack of understanding and awareness of homelessness. Staff at hostels may lack both skills and confidence around complex needs. Staff tend to move jobs frequently and so training is not easily accessed. There are multiple barriers that prevent people experiencing homelessness from accessing the healthcare they need, e.g. inflexible registration and appointment rules for general practice and negative attitudes of staff which have been highlighted, explored and addressed during education and training.

The Homeless Palliative Care Service response

The Homeless Palliative Care Service aimed to help staff deal with end of life issues including

care planning and identifying when a client may be dying.

The service focused on this outcome more broadly by fostering and maintaining connections with services, both regionally and nationally, to raise awareness of the issues relating to homelessness and palliative care across all relevant sectors.

New partnerships were launched in year 4:

- **Partnership working** with Inpatient Palliative Care team at the Manchester Royal Infirmary, including weekly ward rounds.
- **Community outreach 0.5 days per week** with a Consultant in Palliative Medicine.
- Provided **weekly in-reach** support to **two** complex needs hostels.

These activities resulted in more referrals, a 250% increase, and faster referrals at the end of the project compared to the beginning five years earlier.

The Homeless Palliative Care Service was invited by Professor James Kingsland to become a demonstrator site for the 'Complete Care Community Project', an innovative national programme led by NHS England, to address health inequalities to achieve the goals set out in the NHS Long Term Plan.

The coordinators have provided specialist 'trauma informed' training and support sharing their knowledge, insight and in-depth understanding of homelessness and palliative care across Greater Manchester. Training has been provided to around 2,000 delegates across health and

homelessness sectors. During the COVID-19 pandemic training was delivered on-line and afterwards face-to-face workshops resumed. The team are currently part of the Marie Curie Project ECHO (Extension for Community Healthcare Outcomes) programme delivering online learning for health and social care professionals who work with people experiencing homelessness.

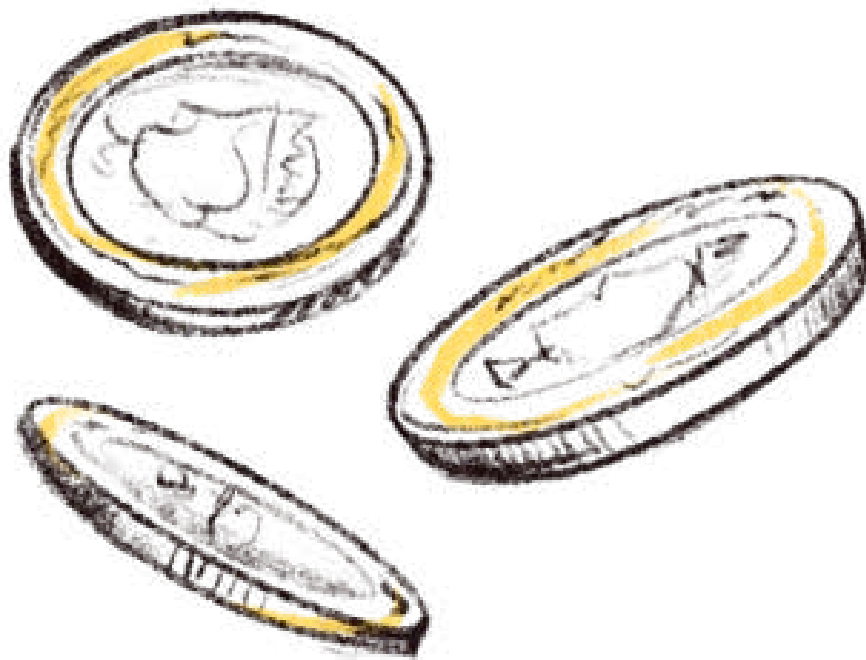
Following online training during the COVID-19 pandemic the team worked with Dr Caroline Shulman, University College London, developing online 'Homeless Complex Needs' Community of

Practice training in Salford funded by the Oak Foundation and NHS England.

A Homeless Awareness Campaign was launched across St Ann's Hospice in Year 3 to enhance the knowledge, confidence and competence of staff in matters relating to homelessness and inclusion health. 100% of staff who attended inclusion health training reported increased knowledge and confidence in supporting patients experiencing homelessness. Hospice staff have also worked alongside the coordinators on 'shadow' days.

Each year, good practice has been shared at regional and national conferences, for example, key note presentations at The Association of Palliative Care Social Workers Conference, the End of Life Partnership Conference, the Stockport Excellence in Palliative Care Conference and the Greater Manchester Combined Authority Inequalities lecture series.

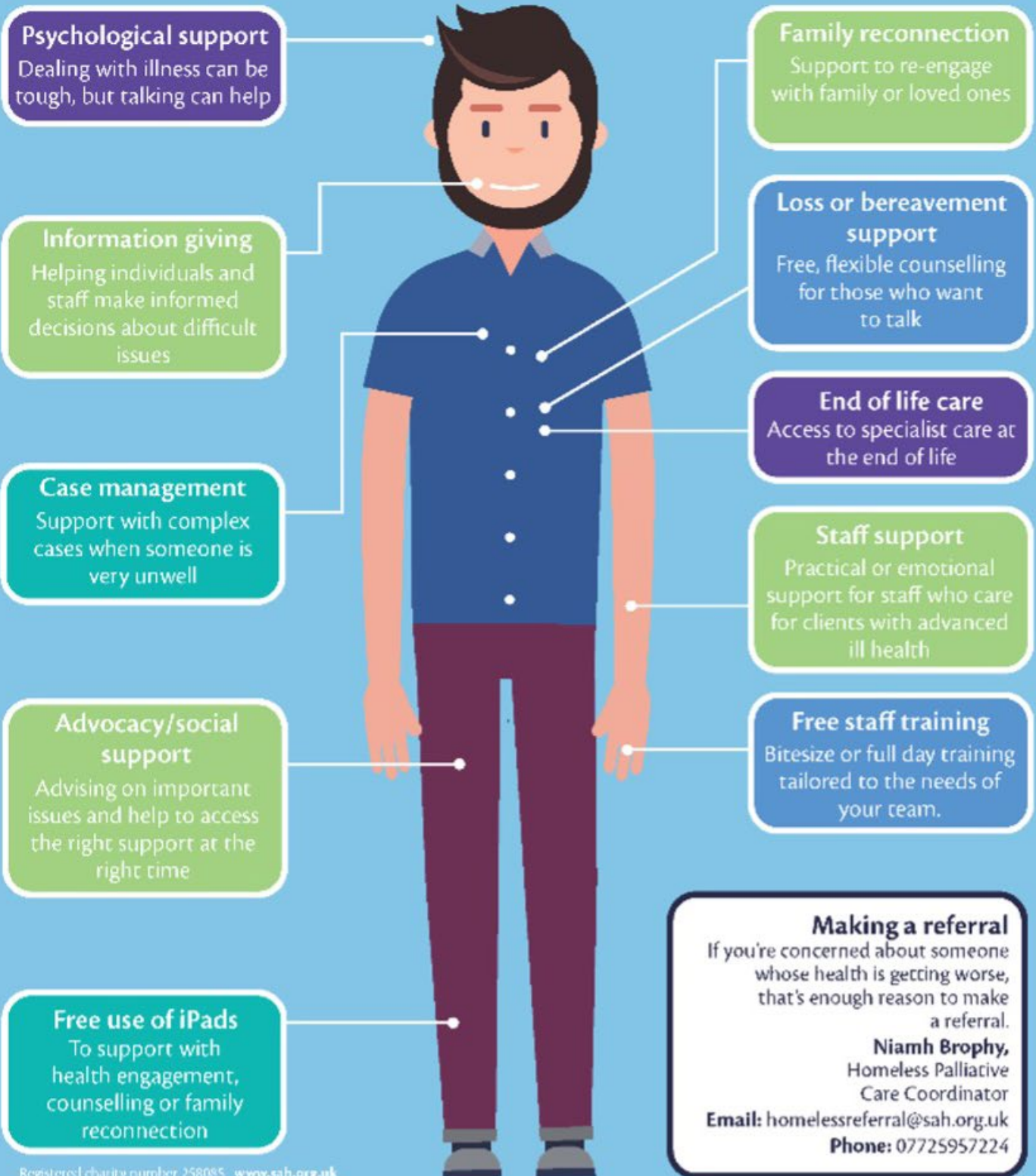
Additional online resources have been developed^{27,28} accessed via the St Ann's website²⁹, where there are links to relevant reports and signposting to other Greater Manchester homeless websites. St Ann's educational film 'Homelessness and Palliative Care' featuring leading voices from the sector, is freely available online for professionals has been viewed 1,800 times³⁰. Leaflets and posters are distributed to hostels and healthcare professionals across Greater Manchester (Figure 7). The St Ann's supporter newsletter, is posted to around 14,000 recipients and emailed to around 13,000 recipients regularly features the Homeless Palliative Care Service.



Do you support someone whose health is getting worse?



St Ann's Homeless Palliative Care Service supports clients, keyworkers and staff teams when someone's health is deteriorating. This can be from Liver Disease, COPD, or a combination of issues. The service can help in lots of ways:



Registered charity number 258095 www.sah.org.uk

Figure 7. Homeless Palliative Care Service leaflet

Outcome/Key achievements from education, training, networks and partnerships

The Homeless Palliative Care coordinators have successfully developed new networks and partnerships and nurtured pre-existing relationships across all ten boroughs within Greater Manchester. Training has improved the skills of clinicians and hostel staff to identify people experiencing homelessness with multiple disadvantages and complex health needs. They are more knowledgeable, more confident and have been able to access psychological support as part of the trauma-informed approach. This year has seen a 250% increase in referrals from the Manchester Royal Infirmary.

The specialist role is recognised and appreciated, 94% of front line staff surveyed reported that the Homeless Palliative Care Service was 'extremely or very effective at improving equity of access and patient outcomes. The survey also revealed that 96% responders 'definitely would' recommend continuing and/or expanding the Homeless Palliative Care Service after January 2025 (when the Big Lottery funding ends) and 5% probably would.

Case Study - Ben aged 58.

Ben was referred to the Homeless Palliative Care Service by his GP in March 2022, after receiving a Cancer diagnosis. He became homeless 30 years previously following a relationship breakdown, which was further exacerbated by Heroin and Crack use.

He was well known to homeless services but struggled to achieve stability; his health began to deteriorate, and he was a 'frequent-flyer' at A&E, often admitted in crisis then absconding or self-discharging. He was living in a hostel where staff felt his needs far exceeded what they could support with and there were concerns about financial exploitation from other residents; Ben's reduced mobility increased his vulnerability.

The Palliative Care Coordinator liaised with Ben's GP, completed referrals to Social Services and the Macmillan Team, requested an MDT and advocated for a care act assessment to be completed to establish his care needs, resulting in a package of care being put in place.

Despite initial improvements, Ben deteriorated further, resulting in several hospital admissions in quick succession. The Palliative Care Coordinator had established Ben's wishes over previous months and in line with these, advocated for an admission to the Hospice. Ben was kept up to date and his wishes remained central to discharge planning.

"I can't fault it, if it wasn't for this place I don't know where I'd be. The staff have been tremendous, I have been treated differently here; before I felt like staff weren't interested in me, but here they've dealt with everything in the right manner. I really appreciate it."

The Homeless Palliative Care Coordinator met with the Ward Manager and staff to update and offer advice and support; the following day Ben has settled and was engaging well. The Palliative Care Coordinator visited Ben again; he said he had never experienced the type of care he was receiving at the Hospice, and that he was happy he was there.

Ben requested support to reestablish contact with estranged family; the Homeless Palliative Care Coordinator supported with this, and his siblings and children began to visit him. Whilst at the Hospice he became a Granddad, and a naming ceremony was arranged at the Hospice; Ben spent the day with his family in the gardens and later told staff it had been 'the best day of my life!'

As is often the case, after weeks of holistic care and support, Ben improved enough to be discharged. He agreed when professionals suggested that the Hostel no longer met his needs and after exploring the options, a nursing home a short distance from his sons was identified and he was discharged there soon after. Notably, this was the first time Ben had completed an inpatient stay.

The Homeless Palliative Care Coordinator spoke with Ben who confirmed the Hospice was now his preferred place of death; this information was passed to the nursing home where Ben continues to reside.

Inclusion Health Barriers

Lack of empowerment, Logistical Challenges and Service Design.

What was important to Ben?

- ✓ To stay at 'home' for as long as possible post discharge.
- ✓ Understanding what is happening to him – clear explanations.
- ✓ To be listened to and treated with respect.

The Homeless Palliative Care Service have worked with partners on research projects, have spoken at national events about their palliative care services and are a demonstrator site with the Complete Care Community Programme.



Cost savings and value for money

Besides the benefits of the Homelessness Palliative Care Service that have been described it has been possible to record some indication of the cost savings of a variety of interventions. There are three examples and a case study for illustrative purposes (Figure 8). The project did not include an economic impact study.

Example	Ambulance to A&E	A&E attendance	Non-elective admission *	Standard bed day**	Critical care cost***	Delayed discharge cost***	Total cost
Cost/day	£367	£418 min	£901	£345	£1881	£395	
1	£734 £367 x 2	£836 £418 x 2	£12,614 £901 x 14	£2,760 £345 x 8	N/A	£16,590 £395 X 42	£33,534
2	£5,505 £367 x 15	£8,778 £418 x 21	£193,715 £901 x 215	N/A	£37,620 £1,881 X 20	£7,110 £395 X 18	£252,728
3	£2,936 £367 x 8	£4,598 £418 x 11	£37,842 £901 x 42	£2,760 £345 x 8	N/A	£9,085 £395 X 23	£57,221

* plus each bed day requiring treatment

** excluding treatment

*** per bed day

Figure 8. Estimated cost savings delivered by the Homeless Palliative Care Service

In example 1, the costs were calculated to be £34K for the nine week stay in hospital (MRI) over two admissions. The Homeless Palliative Care Service were involved at week 2 and coordinated a discharge solution for the end of week 3. There were delays with the discharge. For approximately 6 weeks the patient was medically fit for discharge.

Following and enabling the Homeless Palliative Care Service would have saved >£16.590K.

In example 2, the Homeless Palliative Care Service has been involved for two and a half years during which the cost of care is a conservative estimate of £250K. For the calculations shown above, about two-thirds of a 12-month period spent in hospital MRI (243 days) and two Hospice admissions were coordinated by HPCS. At several points in time, if the advice from the Homeless Palliative Care Service had been able to be implemented earlier, the person would have been transferred to St Ann's Hospice sooner and onwards to a care home, where they still reside. An integrated approach would have resulted in **substantial**

savings and stopped the cycle of in-patient care in an NHS hospital.

In example 3, With coordination from the Homeless Palliative Care Service a 'Frequent Flyer' patient to A&E was discharged to St Ann's Hospice, and subsequently to a suitable care home. They now have an admissions rate to A&E comparable to any member of the general population saving £57,221 per year.

A case study features Mohammed (right). His delayed discharge from the date the Homeless Palliative Care Service requested his discharge into Neighbourhood Apartments was 45 days. **This avoidable cost to the NHS was estimated as £26,370** without taking into account the amount of time he was medically fit before being referred to the Homeless Palliative Care Service.

Case Study - Mohammed aged 57.



“Please help me, I don’t want to die here, I just want my own space.”

What was important to Mohammed?

- ✓ Having privacy and dignity.
- ✓ Leaving hospital as soon as possible.
- ✓ Securing his own accommodation.
- ✓ Having a Muslim burial.

Mohammed was a 57-year-old man with a recent diagnosis of liver cancer. He was admitted to Manchester Royal Infirmary (MRI) in early 2023 and referred to the Homeless Palliative Care Service by the hospital Palliative Care team at the end of April 2023.

Mohammed had worked cash in hand jobs across south Manchester for the 20+ years he had been living in the UK. During this time, he was sofa surfing with different members of his community. He had no history of mental ill health or substance use issues. Socially he had no family in the UK and listed a friend as his next of kin.

The reason for referral to the HPCC centred around the complexity in discharge planning due to Mohammed having no fixed abode. He had been referred to the hospital MPath Team earlier in April, however they advised they would not accept him due to Mohammed’s poor prognosis and the unsuitability of homeless service accommodation for his anticipated deterioration. MPath advised referral to the Complex Discharge Team (CDT), however the CDT did not accept him either given he did not have any current care needs. Mohammed’s discharge was consequently delayed though he was medically fit and ready to leave.

We estimate that the cost of this prolonged stay in hospital (45 days) cost the NHS an avoidable £26,370. This does not take into account the amount of time he was medically fit before referral to the HPCC was made.

What did our partners say? Consultant Palliative Medicine, MRI

“The work the team undertakes to try to get flexibility from otherwise quite rigid NHS services, to allow care that might actually work for these patients, reduce barriers and conflict. Negotiate flexibility on their behalf.”

Advanced Nurse Specialist, MRI

“They were able to advocate for his needs when we were struggling to get his needs heard in the hospital. They signposting to the correct services and procedures. They have excellent links into the community. Off the back of this they are coming to provide some training for our team so we can get better outcomes for our patients, which we are all very excited about”

Inclusion Health Barriers

Logistical Challenges and Service Design, Lack of Empowerment.

Stakeholder Feedback Survey

When stakeholders were asked in July 2024 about the services provided, 73% frontline staff had participated in 'Education and Training', 63% had been involved with 'Case Management', 33% had received 'Emotional and Psychological Support' and 42% had been involved with 'Advice, Networks and Partnerships'. The detailed results are shown in Appendix 2.

The Homeless Palliative Care Service facilitated a range of interventions. The most frequently used was multidisciplinary case management 73%, followed by working across sector and geographical boundaries 58%, advocacy 58% and facilitated discharge 56%. Trauma-informed advanced care planning was used by 55% staff, family reconnection 46% and securing appropriate accommodation 40%. The 'other' category related to increasing awareness of homelessness, education and training.

The survey at the end of the project represented clinical staff 65%, non-clinical staff 31% and in social work and social housing 4%. Of these 45% worked in hospices, 18% in hospital, 14% in the homelessness sector, 10% in the community, 4% in the charity sector and the other 10% work within primary healthcare and General Practice.



The three key challenges faced by the Homeless Palliative Service, as suggested by the stakeholders, are described in detail in Appendix 2. A sample of the stakeholder feedback comment are shown here:

The homeless palliative care team are an outstanding service and I think their continuing work is vitally needed by our population. I think the positive impact they have on patients and staff is invaluable and hugely affects outcomes for these patients.

I feel the service has been extremely successful and is something that has benefited so many people that would never have been able to access our services it definitely needs to continue as it is such a vital service

The relationship with the patients is outstanding! The homeless team go above and beyond with everyone they are in contact with!

It would be a loss to the whole of the city if this service did not carry on after January

I think Heidi and Niamh are doing fantastic work - sometimes it may be hard to measure numerically the value that they bring but they are making a huge difference to the patients they are helping.

The service is definitely needed and one that makes St Ann's stand out as it is not a service that other hospices offer.

The Palliative Care Team are absolutely fantastic and deserve all the plaudits they rightly deserve

They are a unique organisation that support other services with their specialist knowledge. This is invaluable as its working with often the most vulnerable and needy in our society

The St Anns homeless palliative care service provide a great service and it would be a great loss to patient care if this service was not to continue

Great service which ensures people, no matter what their circumstance, have equal access to End of Life support & services.

Their values and proactive 'can do' attitudes rubs off onto the whole team

It's been great having the homeless palliative service, it's definitely improved the care of homeless people - increasing access to services. It has also raised my awareness of the needs of homeless people and how I can support them. Thank you

Figure 9. Stakeholder feedback 2023

Challenges, learning points and recommendations

Key challenges for the St Ann's Homeless Palliative Care Service are:

- The service is funded as a scoping project for 5 years, with no confirmed funding to ensure service continuity beyond January 2025.
- 1.4 FTE Homeless Palliative Care Coordinators to cover the Greater Manchester footprint, resulted in limited capacity to meet increasing demand.
- Lack of **appropriate accommodation** for people with advanced, deteriorating ill health and complex needs proved to be a significant gap in provision, resulting in PEH living in spaces that did not meet their needs, or remaining in acute medical beds far beyond the point of being medically fit for discharge.
- Workforce development is often thwarted: **training delivery** for frontline staff is well received and highly valued, however staff turnover limited its impact.
- **Peer support** was not part of the project, due to limited capacity to develop it.

What the St Ann's Homeless Palliative Care Service has learned:

- Their innovative, flexible, evidence-based model of care enables vulnerable people to achieve a **better quality of life**, giving them the opportunity to consider what is important to them in their final months, and increasing the likelihood of them dying in **a dignified way, in a place of their choosing**.
- It elevates the voices of those with lived experience of homelessness and multiple disadvantage who have found themselves **excluded from mainstream services**. From a place of **trust** it provides comfort to individuals knowing that someone is **advocating for them** and that they won't be forgotten.
- The difference that this makes to people who are homeless and approaching the end of life, as well as those who may be supporting them, is in many ways **immeasurable** and without a doubt **invaluable**.

- The care coordinators have an **expert level of knowledge** of homelessness, health inequity and palliative care enabling them to deliver cross-sector education and training to improve equity of access, confidence, skills and outcomes to other front-line staff.
- The job share model has enhanced service delivered to patients and other staff. Without this the role would have been very isolated. **Clinical supervision is essential** for co-ordinators following trauma informed principles.
- The co-ordinators need expertise and experience with both homelessness and health care since this is a highly specialised professional role.
- It has the unique ability to work fluidly across geographical, service and sector boundaries using a best practice approach to multi-disciplinary working. The service is not in a silo.
- The co-ordinators have provided confidence, encouragement, support and improved the skills of all staff to meet the challenges and not shy away from them.

Recommendations from the St Ann's Homeless Palliative Care Service for the hospice sector are:

- There is an absolute need for this hospice-based service. Investment is required across Greater Manchester.

The care coordinators must have specialist knowledge and professional experience of homelessness in order to deliver specialist services that understand the needs of vulnerable populations and deliver patient centred care.
- Use innovative, flexible and personalised approaches. Treat people differently to ensure they are treated equally. Over time, consistent trauma-informed care allowed clients to develop a trusting relationship.
- Increase the outreach work that proactively identifies and engages with clients.

- The service has worked better with a job share and having complimentary skills across professional experience of homelessness.
- Maintain multidisciplinary team working in partnership to address multiple disadvantage.
- Ways of working can be adopted from the service, the scoping project used continuous improvement and ongoing evaluation to rapidly change and adapt.
- Continue and improve by measuring impact including data on hospital admissions, rapid discharge, reduced GP appointments and preferred place of death.

Recommendations from the St Ann's Homeless Palliative Care Service for Inclusion Health:

- Ideally, services need to be commissioned through Greater Manchester frameworks such as Greater Manchester Integrated Care Partnership to facilitate cross boundary working. A hospice is best placed to host this trusted service.
- Aim to ensure that existing resources are allocated optimally and equitably to achieve better outcomes. Resolve the tensions between national priorities and any local priorities not just redistribute the budgets.
- Use funding models, a less rigid commissioning model, that allow broad but flexible outcomes and innovation to provide bespoke services that result in better patient outcomes.
- Adopt the 'learning systems' approach. Complex organisational structures, hierarchies of power and budget constraints can all impact on the sharing of information.
- The provision of accommodation that meets the needs of people experiencing homelessness with advance, deteriorating health and complex needs, is critical in improving the outcomes and experiences of death and dying.



Appendix 1

Methodology St Ann's HPCS evaluation

JG Technology Management Ltd were commissioned to undertake an evaluation of the programme. This final evaluation is an analysis of progress, outcomes and impact for beneficiaries and value for money. The research for this final stage was undertaken through:

- Review of progress reports and other documentation provided by the care coordinators delivery team. Collation of data collected over the programme from staff, beneficiaries and wider stakeholders, e.g. annual reports to the Big Lottery Fund, data dashboard, case studies and post-training surveys.
- Interviews with the care coordinators delivery team.
- Interviews with Clinical Director and Palliative Care Consultant
- Stakeholder online survey.
- Qualitative research with staff, beneficiaries and wider stakeholders.
- Analysis of the resulting quantitative data.
- At the Final evaluation stage, consultation was carried out via an online survey to sent all staff/volunteers who had assisted delivery and was issued to ~200 recipients and 25% responded.
- Feedback from the team is also included and six case studies highlighting the impact of programme support on beneficiaries.

The Homeless Palliative Care Service proposal had already included a formative approach to evaluation, where evaluation has been ongoing and has fed back into management and planning processes to inform the development of the project as it progressed. As such it has been a vital management tool because, critically, formative evaluation highlights the key lessons achievements and issues as they arise, enabling informed decision-making about the future direction of the project.



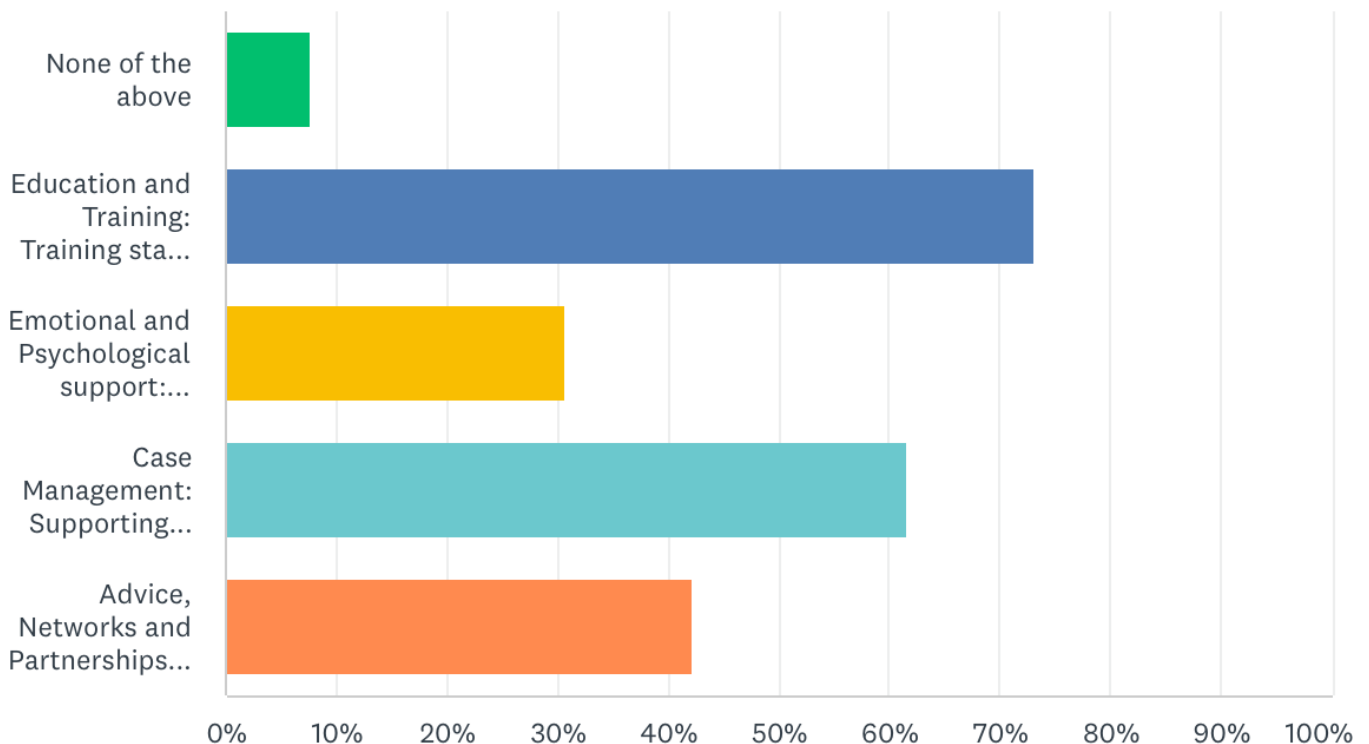
Appendix 2

Final Survey Data

A range of staff involved with meeting the needs of those experiencing homelessness with advanced ill health shared their experiences and evaluated the HPCS service. The responses came from 52 participants throughout July and August 2024. These represent 62% clinical staff, 33% non-clinical staff and 5% other (social worker and area housing manager). Of these 44% worked in hospices, 17% in hospital, 15% in the homelessness sector, 10% in the community, 4% in the charity sector and the other 10% work within primary healthcare and General Practice.

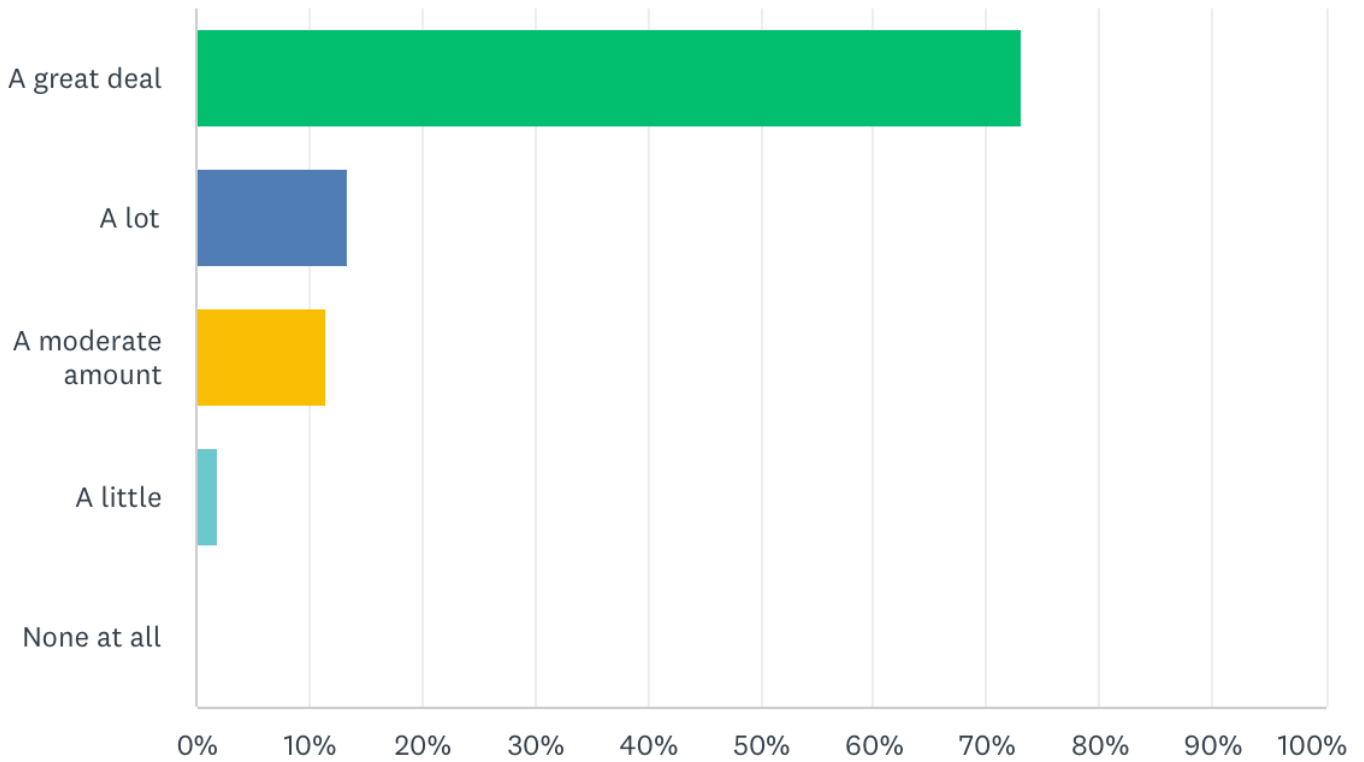
The Homeless Palliative Care Service was established to achieve four main outcomes and 73% staff had participated in 'Education and Training', 63% had been involved with 'Case Management', 33% had received

'Emotional and Psychological Support' and 42% had been involved with 'Advice, Networks and Partnerships' as shown here.



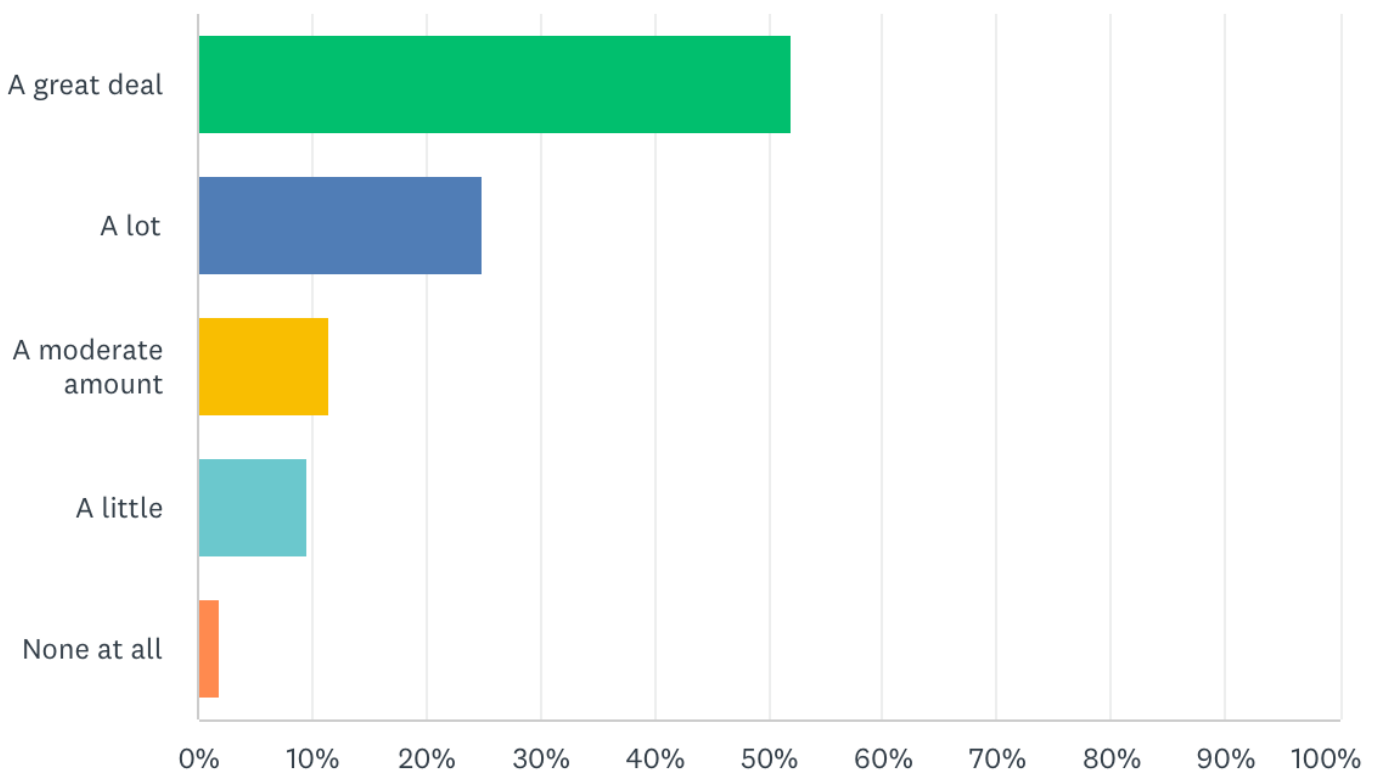
When asked if the HPCS “improved your ability to support people experiencing homelessness who have advanced ill health?” the responses were all positive, 75% responders

said the HPCS “improved their ability a ‘great deal’ and 13% responders said the HPCS “improved their ability ‘a lot’.



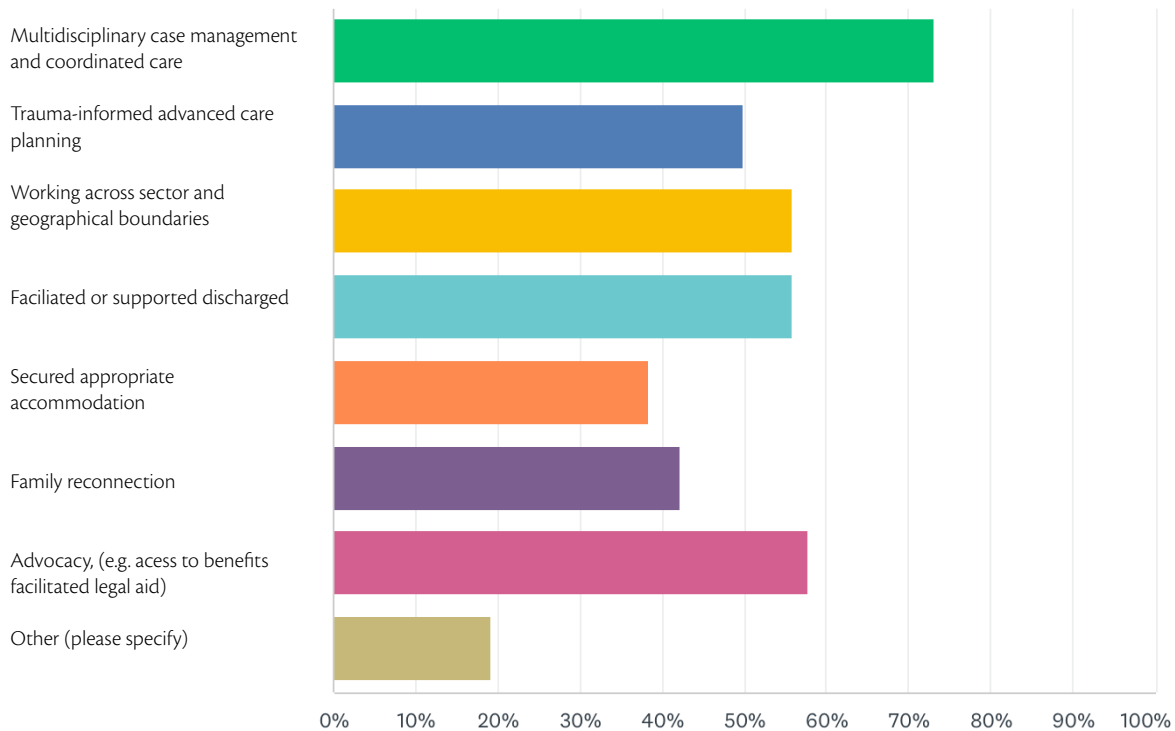
All of the survey participants, except one, reported that the Homeless Palliative Care Service increased access to palliative care for their organisation’s patients/clients with 53% saying it had “increased a great deal”

“Since we have had the HPCS we have had an increase in homeless/rough-sleepers access the hospice’s IPU”.



The Homeless Palliative Care Service facilitated a number of interventions as shown in the chart below. The most frequently used was multidisciplinary case management 73%, followed by working across sector and geographical boundaries 58%, advocacy 58% and facilitated discharge

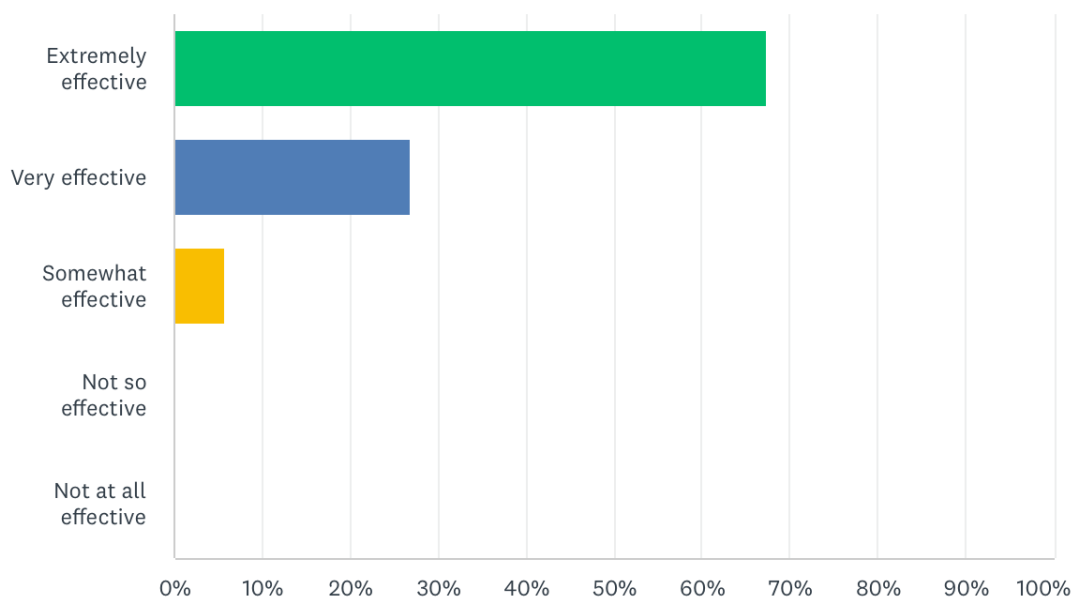
56%. Trauma-informed advanced care planning was used by 55% staff, family reconnection 46% and securing appropriate accommodation 40%. The 'other' category related to increasing awareness of homelessness, education and training.



When asked how effective is the Homeless Palliative Care Service at improving equity of access and patient outcomes, 69% responses said 'extremely effective' and a further 25% said 'very effective'?

accommodating and this has improved equity of access”
 “A patient who had been very vulnerable in the community had accessed hospice services and although the outcome was very sad it was a positive outcome for this particular person as their worst fear was dying alone on the streets.”

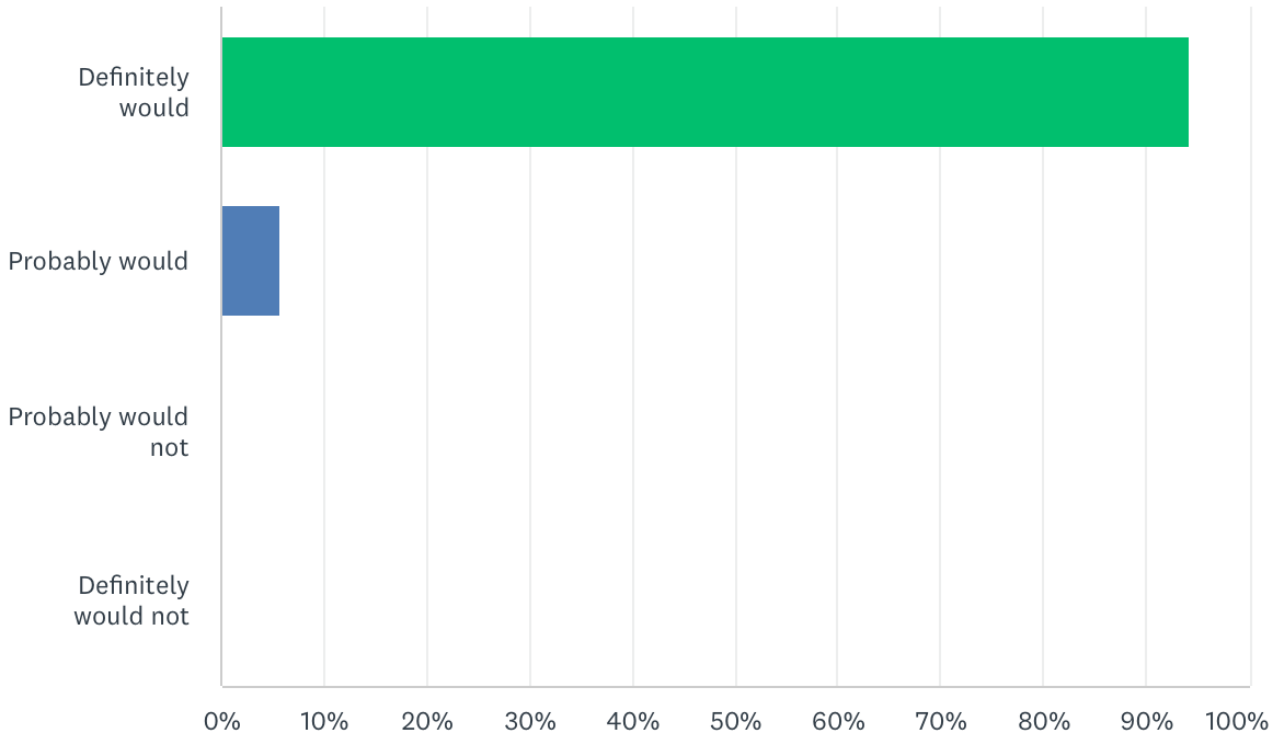
“I feel the HPCS liaison has helped the hospice be more



The survey revealed that 96% responders 'definitely would' recommend continuing and/or expanding the Homeless Palliative Care Service after January 2025 (when the Big Lottery funding ends) and 5% probably would.

"The HPCS needs to continue offering their support to this 'hard to reach' community. For every single person who has hospice support that is one less person who either dies in a hostel or on the street without the professional help that is needed."

"We cannot let this service go. It has been amazing!"



The three key challenges experienced when supporting people who are homeless with advanced ill health.

Key Challenge 1	Key Challenge 2	Key Challenge 3
Stable accommodation	Conversations with young people with palliative care needs	Coordinated care across geographical boundaries / patients with unstable chaotic experiences / inability to draw in existing community services to support patients
Relationship building	n/a	n/a
Discharge planning	Encouraging homeless individuals to accept hospice services	Education on drug and alcohol use within the homeless community
Making our services work around their lifestyles which can be chaotic	Establishing a good working relationship as many of the homeless patients have had bad experiences with healthcare professionals	Being able to support patients with history of trauma and understanding what we can do and what is beyond our ability
Building a rapport and gaining trust	Preconceptions	n/a
if drug use is involved, the addictive behaviours are challenging to manage in an institutional setting	An address to discharge to if patient's condition stabilises enough.	n/a
Stigma	acceptance of support	n/a
Understanding guidelines of the Hospice when admitted.	Dealing with challenging behaviour.	n/a
Recognising palliative care needs in young people	Helping patients coordinate care and access to different services	Anticipating common problems faced by these problems to better address needs
Access to medication	Maintenance of good pain control	Poor compliance with services
No suitable place for them to stay	in the past no where to turn to.	MDT working for palliative care.
Getting services to engage with them	n/a	n/a
Lack of appropriate accommodation for people to die at home with dignity	Hospital not always supportive of palliative care referrals for those with complex needs	Community nursing organised in geographic neighbourhoods impedes access to support for those registered with our GP practice but are residing outside the practice area
Self neglect	Lack of family/friends support	Particularly advanced ill health
Building a relationship	Understanding their situation	Not getting too involved
Safe place for discharge	ensuring patient receives follow ups	patient receiving medications
The advanced ill health not being recognised by clinicians as needing palliative care discussion/planning	Lack of access to appropriate support including a hospice bed.	Complexities of physical & mental health problems, substance use, trauma, & chaos of having no fixed abode.

Key Challenge 1 (Continued)	Key Challenge 2 (Continued)	Key Challenge 3 (Continued)
Healthcare services not understanding the specific needs of homeless patients	Multiple health issues (namely drug/alcohol and mental health issues) impacting on some homeless patients abilities to access and stay in touch with other healthcare services	n/a
Engagement in services	Limited services available for discharging them	Prejudices against the patients
Discussion around discharge	After death care - who arranges the funeral	Worried about their support system
Engagement	Building relationships	Perceptions by others of homeless people
Accommodation	Discharge	Symptom control in unusual circumstances
Transient nature - unable to maintain contact	Trauma and negative experiences that people have been through can lead to challenging behaviours	Limited support network
Establishing connections with the homeless community	Adapting our service to meet their needs i.e. drop in appointments, meeting them in their own environment etc.	n/a
Continuity of support	Safe medication dispensing	Complex health problems
Access to care	Willingness to access care	Education for people in care environments
Lack of respect for the patient	Inability to express needs	Lack of knowledge re what's available
The right hostel or placement of accommodation	Pressures on Hostel staff and encouragement that they are doing the right thing	Linking in with the hospice and handing over care
ACP conversations	Supporting people to die where they want	Lack of joined up services
Support with addiction	Engagement from the client	None compliant with medication
Patient engagement	Preconceived ideas	Consistency
Chaotic lifestyle	Hard to break habits/lack of cooperation	n/a
Getting support from Home Office to regularise their status	Finding suitable accommodation to support them	Not having all the required information to support them
Inequitable access to services	Difficulty setting achievable goals in patient-context	n/a

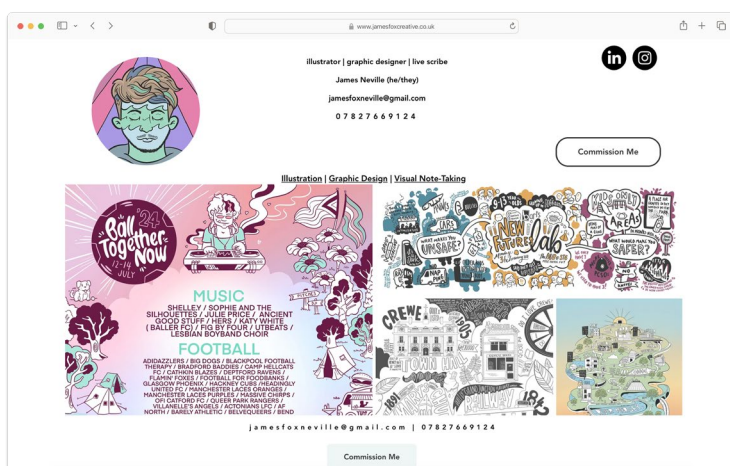
Key Challenge 1 (Continued)	Key Challenge 2 (Continued)	Key Challenge 3 (Continued)
Typical services not designed for those who struggle to access	Typical services not designed to be flexible to cultural needs	Typical services being inflexible for those with behaviours that are seen as "a problem"
How patients who have experienced trauma can deal with the end of life issue well	Difficulties from supporting services in offering care	People on methadone already and how to give good pain relief
Mental health	Poverty	drug issues
Building positive relationships.	Understanding background and complex psychosocial needs.	Understanding trauma informed care/communication.
Education around homelessness		n/a
Insecure & unsuitable accommodation	Irregular access to medical/social services	Substance misuse impacting on treatment
Drug misuse	Relocation issues	Safeguarding from financial abuse
Access	Drug management	Supporting whilst in the hospice
Multiple disadvantage doesn't neatly fit into existing services - eg substance use and experience of rough sleeping	Behaviours of the person making management tricky	Usually earlier age of person making existing services less appropriate
Associated drug and alcohol misuse	Difficulty engaging with the service	Staff relationships/stigma - I feel this very often needs to be overcome and additional support helps us do this
Advocacy around parallel care planning	Securing accommodation	Dignity respect choice connection
Communication through the health teams	Understanding the end of life process / having someone on hand to advise & support	Making the family links in some instances of estranged families
Refusing services	Discrimination of service users	Lack of Knowledge to services
Understanding guidelines of the Hospice when admitted.	Dealing with challenging behaviour.	
No exit plan from our accommodation if their prognosis is not end of life	Not having the right support or professionals involved	Not knowing where to go for support
Getting them to understand the help they can receive	Getting them to accept that help	Getting in touch with clients rough sleeping without a phone to make them aware of appointments
Suitable accommodation	Multi agency meetings who know patient	Practical items /advice

Additional comments

Feedback on the Homelessness Palliative Care Service
The homeless palliative care team are an outstanding service and I think their continuing work is vitally needed by our population. I think the positive impact they have on patients and staff is invaluable and hugely affects outcomes for these patients.
I feel the service has been extremely successful and is something that has benefited so many people that would never have been able to access our services it definitely needs to continue as it is such a vital service
The relationship with the patients is outstanding! The homeless team go above and beyond with everyone they are in contact with!
It would be a loss to the whole of the city if this service did not carry on after January
I think Heidi and Niamh are doing fantastic work - sometimes it may be hard to measure numerically the value that they bring but they are making a huge difference to the patients they are helping.
The service is definitely needed and one that makes St Ann's stand out as it is not a service that other hospices offer.
The Palliative Care Team who cared for 2 service users at Newbury House are absolutely fantastic and deserve all the plaudits they rightly deserve
They are a unique organisation that support other services with their specialist knowledge. This is invaluable as its working with often the most vulnerable and needy in our society
The St Anns homeless palliative care service provide a great service and it would be a great loss to patient care if this service was not to continue
Great service which ensures people, no matter what their circumstance, have equal access to End of Life support & services.
Their values and proactive 'can do' attitudes rubs off onto the whole team
It's been great having the homeless palliative service, it's definitely improved the care of homeless people - increasing access to services. It has also raised my awareness of the needs of homeless people and how I can support them. Thank you
Niamh and Heidi, are responsive and committed professionals working in highly stressful situations. they always have time to discuss concerns present solutions and share their knowledge. They deliver meaningful education and are role models to staff in the organisation.
Excellent A massive thank you to Heidi, I personally have learnt a lot and am so impressed by the compassionate and professional approach she has. service which really help [sic] a service user at the end of her life.
Heidi was absolutely brilliant both in her training delivery, her continued contact with us where needed, and in her advocacy for and communication with patients.
A great team of two who work hard in providing a service for people who can't always advocate for themselves
Really great team - need more of them!!!!
The team are very friendly and helpful. They seem to care deeply for their patients which show a good quality in the team
Very high quality care and training delivered by experienced and intelligent practitioners
I think this is a really good service which is benefited an important part of our population and similar work needs to be done in other regions to replicate the fantastic work St Ann's is doing.
They have been great. This service needs to be funded permanently.
Really valuable specialist area that is really valued by our service

Additional comments continued

Feedback on the Homelessness Palliative Care Service continued.
Continued support with the IPU following admission. Passionate about what they do and go above and beyond their roles to support homeless clients.
We feel this is a really beneficial service in not only promoting access to palliative care, but also in educating staff around homelessness
Knowledgeable and capable support work familiar with client group
We need the service, it is vital for inclusivity
Extremely beneficial service
A valuable service that needs to be maintained
Great team great service and much needed
A great training sessions! [sic]
Very much enjoyed the training session. Would like to continue to link in with other activities
Thank you for all your support - we really appreciate it
Brilliant to work with you guys, and thanks for all you have done
Brilliant service
Very helpful
Excellent
Thank you
Well done to the team for all they have achieved in such a short time-frame. May it continue
Great resource
Amazing services, amazing staff team
A fantastic invaluable service which should definitely continue
I think this is a really good service which is benefited an important part of our population and similar work needs to be done in other regions to replicate the fantastic work St Ann's is doing.
They have been great. This service needs to be funded permanently.
Really valuable specialist area that is really valued by our service



Credits of Illustrations
Should you have any queries,
please email:
www.jamesfoxcreative.co.uk

Appendix 3

- ¹Hudson, B.F., Shulman, C., & Brophy, N. (2017). Time to link palliative care and homelessness services. Inside Housing. <http://www.insidehousing.co.uk/time-to-link-palliative-care-and-homeless...>
- ²<https://www.pathway.org.uk>
- ³Integrated health and social care for people experiencing homelessness, (2022), NG24 NICE. Published: 16 March 2022 <https://www.nice.org.uk/guidance/ng214>
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