November 2016 Clinical Senate: Homelessness – No fixed address – Can we still deliver care?

Recommendations endorsed by Director General in July 2017

WA Health Actions to be reported back on August 2018

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Response to the recommendations

An important aspect for reporting activity addressing the recommendations is identifying the overall status (level of implementation) for activity. This is a required field. Please use the table below to select the most appropriate status level for each recommendation.

Table 1: Overall status of the recommendation at last update	
Level of implementation	**Outcomes that may have been achieved**
Discontinued	The recommendation has been discontinued. Please provide further information in the 'Comments' section.
Level 1: **No/little progress**	Outcomes include: Components to deliver recommendations may have commenced (e.g. the establishments of a governance structure and/or scoping of a plan) but the project has not progressed further.
Level 2: **Partial implementation**	Outcomes include: Governance has been established and formal plans have been endorsed. Change has commenced and/or resources have been allocated (recruitment or training of personnel, development of procurement procedures etc.)
Level 3: **Substantial implementation**	Outcomes include: Processes and/or procedures to deliver the recommendation have been established and the timetable for full implementation is almost complete and/or milestones have been achieved.
Level 4: **Full implementation**	Outcome: The recommendation is fully implemented.

Recommendation	WA Health Actions	Responsible office	Start	Expected end	Progress to date	Next steps	Current status
Part A: For the attention of the System Manager							
Endorsed 1: The Clinical Senate asks the Director General to brief the Minister for Health and seek his views as to whether or not he wishes a Cabinet submission to establish a cross jurisdictional Cabinet Committee (Department of Health (DoH), Department of Child Protection & Family Services, Department of Education, Department of Corrections, Mental Health Commission) to coordinate initiatives to reduce homelessness and its sequelae of prison, high hospital admissions, sub-optimal school attendance and other social issues.	Prepare a letter from the Director General to the Minister regarding the Clinical Senate's recommendation that the Minister of Health consider the merits of a cross jurisdictional Cabinet Committee to lead and coordinate initiatives to reduce homelessness.	Office of the Chief Medical Officer (OCMO)	August 2017	July 2018	A meeting was held with Department of Communities (DC) in October 2017, as the DC was identified to be the lead agency for the coordination of funding for homelessness services in WA. DC has a Senior Officers Group (SOG) on Homelessness which was established to oversee the implementation of the National Partnership Agreement on Homelessness (NPAH) 2009-2013. There are three representatives across the WA health system on SOG. A meeting was held with a DoH SOG representative in October 2017 to get a better understanding on the WA health system's involvement in this area to inform the implementation of the Senate recommendations. In 2018, the SOG undertook a stocktake of homelessness service provision in WA across government departments. Health Service Providers (HSPs) activity was provided for the stocktake. The stocktake will guide the development of a long term strategic homelessness plan and reform new and existing contracts to the homelessness services sector. The Plan is due for completion by the end 2018. Rather than establishing a Cabinet Committee, an alternative forum was identified to enable WA Health to be involved in a senior cross-agency advisory body to the government on homeless matters- the WA Council on Homelessness (WACH). WACH was established by the Minister for Child Protection as an external advisory body to the Government on homeless matters (Terms of Reference). Members of WACH include representatives from all of the Departments mentioned in the recommendation above except the WA DoH.	WACH was confirmed to be an appropriate and established cross agency committee to advise the government on matters related to homelessness. Correspondence was sent in April 2018 to the Hon Simone McGurk MLA, Minister for Child Protection; Community Services from the Hon Roger Cook, Minister for Health; Mental Health requesting a nominee from the WA health system be included on WACH.	**Full implementation** A representative from WA Health has been nominated on WACH. Through membership on WACH, the WA health system will have an avenue to contribute to state planning for homelessness, provide advice to the government on current and emerging issues affecting homelessness and to ensure health services are connected with other government and non-government services.

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Part A: For the attention of the System Manager							
Endorsed 2. That WA Health adopt a standardised definition of homelessness. This definition should be used when collecting information from Health Services. The definition should be incorporated into central referral notices from primary care and in discharge summaries to assist with data collection.	The System Manager in collaboration with Health Service Providers (HSPs) to produce an agreed definition of homelessness. This process should be achieved at a meeting between suitable system manger and HSP nominees. The System Manager to encourage HSP Safety and Quality committees to review homeless statistics within their HSP catchment using the System Manager's endorsed definition. This would involve the System Manager writing to HSPs and asking them to consider this action.	OCMO	September 2017	August 2018	A review was undertaken of definitions of homelessness currently used in WA, nationally and internationally. The DC have a clear definition of homelessness which is aligned with the Australian Bureau of Statistics definition and is used by the Australian Institute of Health and Welfare for specialist homelessness online reporting from a range of agencies. Homelessness is often a transitory arrangement where a person may move between different levels of homelessness. It is acknowledged that the less chaotic homeless such as those that are couch surfing or have no tenure need to captured under the definition of homelessness. This allows opportunity to intervene earlier in the health care pathway and provide appropriate referral to support services before living arrangements become more chaotic and health needs more complex. The broader definition proposed for the WA health system to adopt will encompass these groups. It was identified that current data entry into patient administration systems varies across HSPs. Following consultation with Health Support Services, webPas Site Administrators, Purchasing and System Performance and data custodians and analysts at the Department of Health it was determined that more consistent data entry was required for homeless patients.	The System Manager will communicate to HSPs that they are encouraged to use a standardised definition of homelessness and data entry practices for homeless patients on webPAS.	**Full implementation** A report has been sent to Board Chairs and the Chief Executive's of HSPs informing them of the following recommendations: 1. Health services are encouraged to adopt and promote the standardised definition of homelessness. 2. HSPs are encouraged to review their data entry practices in this area and adopt the data entry practices for homeless patients specified in the report. The webPAS Patient Master Index guide will be updated to reflect the change to patient administration.

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Endorsed in principle 3. WA Health gather and analyse data on our homeless patients to inform the development of a WA Standard of Care (previously model of care) for homelessness that includes the elements of: • Education and Training • Professional practice standards Code of ethics • Code of conduct • Culturally safe care • Culturally safe practices • Safety and quality frameworks • Patient experiences/evaluation of care. It is noted that Royal Perth Hospital (RPH) has a model and it should be examined and considered for adoption by other health services.	Review of existing health professionals' standards of care and training related to homeless patients, Including consultation with Dr Amanda Stafford's Homeless Team and Joanne Wilcox, Senior Social Worker at Sir Charles Gairdner Hospital (SCGH). Other non-government organisations with expertise in this area have indicated a willingness to be involved in developing the model of care. These include Anglicare WA, RUAH, St Patricks and Youthlink/Youth Reach. Present the RPH model to other HSPs for their consideration.	OCMO	September 2017	August 2018	Two Standard of Care packages relevant to homelessness were identified which may have relevance for the WA context. Pathway in the UK have developed standards of care and associated training programs for homelessness. The Department of Child Protection (DCP) has Specialist Homelessness Services Standards Guidelines. The standards aim to promote good practice in service provision for homeless people or those at risk. The standards are for use by DCP. There are 14 SHS Standards in the DCP Guidelines and these are organised under five categories: direct service provision, client's rights and participation, integrated service system, service management and health and physical safety. Two recent patient surveys specific to homeless patients conducted in WA were identified, the 50Lives50Homes project at University of WA and the interviews with homeless older women undertaken by Notre Dame University. The elements of the Standard of Care mentioned in the recommendation were confirmed to be part of existing professional standards and mandatory training requirements across the WA health system. Therefore it was proposed that the development of staff education packages specific to working with homeless patients would be more beneficial. The education packages would also support the Health Service Boards to meet the requirements of recommendation 1 (see Part B below). The Clinical Lead of the RPH Homeless Team was consulted in October 2017 regarding the applicability of the RPH Model for other HSPs. It was suggested that the RPH model is unique to the level of patients serviced at RPH. RPH are currently collecting data on the success of the program. A report on the first 18 months of operation is available here.	A report which includes a demographic profile of homeless people in WA as well as health service utilisation data was prepared for HSPs. Three education packages have been developed to support staff working with homeless patients. Online education: Delivering Quality Care to Homeless Patients The slides include: • health profile of homeless people • overview of the social determinants of health • how Trauma Informed Care Models can assist in delivering quality care • useful questions to ask homeless patients under your care Report: Working with Patients in a Clinical Setting This report includes tools and practical recommendations that may assist Junior Medical Officers during consultation and treatment of a homeless patient. The report includes: • barriers to health care • trauma-informed care • addressing patient resistance • evaluation of living conditions • development of a care plan • guidance in referring a homeless patient and list of relevant WA local services. Checklist: For clinicians providing care to homeless patients and summary of key support services for referral.	**Full implementation** The report was sent to Board Chairs and the Chief Executive's of HSPs in August 2018.

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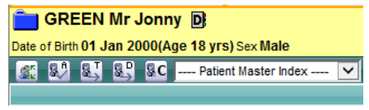
Endorsed 4: The System Manager add an alert to referrals which identifies people who are homeless or at risk of being homeless and: − Allows referral to choose appropriate facility or service for patients care outside of Central Referral Service (CRS) post code boundaries − Notifies patients GP of appointment details − Patients referral to be prioritised − Homeless people to be identified at triage	The System Manager, in collaboration with HSPs, review the way data is entered into the current patient information systems to enable a coding and alert for homelessness.	CMO	September 2017	August 2018	Current definitions used in TOPAS and WebPAS for homelessness and limitations were considered. 'No Fixed Address', 'UNKNOWN' and 6999 are used where no postal address can be identified. It was identified that the best approach would be to add a homeless folder selection and colour coded flag to webPAS systems across hospital sites. A similar enhancement to webPAS is used for prisoners. Consultation on this amendment occurred with HSS and webPas site administrators. It was confirmed by CRS that homeless patients are already being allocated to outpatient services outside specified postcodes where the GP informs them of the easiest service for the patient to attend. A pilot project at RPH, undertaken by Laura Clappinson, considered 'Did Not Attend' (DNA) rates for outpatients' appointments. Advice suggested the 'No Fixed Address' listing may not be noticed until an appointment letter label is generated. Additionally the project identified that homeless patients tended to not be discharged for DNAs, however it was recognised rates of attendance will continue to be low if the underlying reason for the lack of attendance is not addressed.	HSS to implement the webPAS changes for the homeless folder selection and colour coded flag. The webPAS Patient Master Index guide will be updated to reflect the change to patient administration.  Folder selection will trigger change in colour of folder to blue. 	**Partial Implementation** The report sent to HSPs provided an update on these changes. The changes will enable homeless patients to be more readily identified at triage so appointments can be prioritised and referral to services outside of CRS boundaries.

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Endorsed in principle 5: That the System Manager determines the presenting diagnosis of the high cost or prolonged length of stay (LOS) admissions in homeless people and then considers proactively sending specialist care in these disciplines into the community to reduce admissions and LOS e.g. Dental/Podiatry.	Chair of the Clinical Senate to write to the Healthway Board (and any other relevant research funding body within WA Health) and ask them to call for applications that might address this output and fund a research project to produce a model of care for homeless people based in primary health care that will reduce hospitalisations and other avoidable health costs from its current pool of funds. Funding of a $100,000 project with a deliverable outcome to be achieved within 24 months would appear reasonable.	Clinical Senate	September 2017	February 2019	A letter was sent to Healthway Board, following which there were several letters, emails and a face to face meeting regarding this issue. It was agreed between the parties that the topic for consideration was clinical and therefore outside of Healthway's remit. OCMO undertook a review of data on homeless patients. This included consideration of emergency department (ED) presentations and frequency of re-attendances, hospital separations with average LOS and average costs. The top ten diagnostic related groups (DRGs) for separations and the top ten DRGs for LOS and cost were identified. OCMO also funded Royal Perth Hospital to undertake a pilot project which aims reduce the demand on EDs and increase the availability of inpatient beds during the Winter Demand Strategy period in 2018. The project will support appropriately planned, expedited discharge of homeless patients following presentation to ED or hospital admission, including supporting priority transport, accommodation and outpatient medication needs during the peak winter period. The project will also promote immunisation using the influenza vaccine among homeless patients discharged from RPH to prevent further ED attendances or admissions. Changes in emergency department presentations, hospital admissions and length of stay for homeless people over the period of the pilot will be compared to the previous year. The report will be available in early 2019.	Undertake the evaluation of the Winter Care Strategy. .	**Full implementation** The report to HSPs included data on hospital utilisation.

Part B For attention of the Health Service Boards			Recs sent to HSP's	Response Received from HSP's	North Metropolitan Health Service	South Metropolitan Health Service	East Metropolitan Health Service	Child and Adolescent Health Service (CAHS)	WA Country Health Service
					Initial Responses				
1: The Health Service Boards consider investing in staff education that evaluates the social determinants of health and the linkages to homelessness. The package could address: 1. The relationship between mental health and homelessness 2. Personal bias towards homeless people and how attitudes effect care 3. The knowledge to connect homeless people into community services 4. Trauma informed care models.	FSH has already developed a resource booklet for patients who present at FSH who are experiencing or at risk of homelessness. This booklet might be revised for use by other HSPs. Non-government homelessness services may be willing to help provide training on a voluntary basis as part of their Mission. Letter to be provided to HSB to consider.	Clinical Senate	July 2017	July 2017	**Endorsed** - There is value in having standardised and cross-sector education. The issues surrounding the relationship with mental health, the personal bias towards homeless people and trauma informed care are universal. Community services could be the provider of this training, which would at the same time support the transfer of knowledge of how to connect people to community care. Additionally, education can be undertaken formally and informally and information can be provided by employers, schools, universities and to the broader community. Any bias we may have is not unique to health employees and improved community awareness would provide much broader support to people who are homeless.	SMHS is embarking on the development of an education framework to ensure staff are aligned to the Boards vision of delivering "Excellent Health Care every time." This vision encompasses all patients including those who are homeless. It is anticipated that an analysis of staff's learning needs, will feed into this plan.	East Metropolitan Service has played an integral role in the implementation of the recommendations for the system manager. They currently have a Take 5 education package titled *Delivering quality care for homeless people.*	Overarching Response: As part of the CAHS strategic planning process, the CAHS Board will consider how the recommendations can help to improve the services provided by CAHS. The report provided by the Office of the Chief Medical Officer has been referred to the Board's Safety and Quality Committee for consideration.	Overarching Response: WACHS is working on development of pathways for homeless patients and mapping of resources and services to support homeless people in the regions. WACHS will also work to implement the webPAS alert across our system, capture data relating to utilisation of services and educate staff.

2: That Health Service Boards consider how they will manage homeless patients within their catchment area. A Hub and Spoke process is recommended by the Clinical Senate, with a centralised source of expertise that peripheral facilities may access as required.	RPH Homeless team have developed an excellent Hub and Spoke service that other HSP may either adopt locally within their own HSB catchment area or else work with her group to act as a State-wide Hub and then provide only local spoke access within their own facilities. Letter to be provided to HSB to consider.	Clinical Senate	July 2017	July 2017	**Not Endorsed** - It is acknowledged that East Metropolitan Health Service (EMHS) has developed an effective model in response to their local circumstances and one that reflects the needs of their population. Royal Perth Hospital has always been a hub for homeless people who live in the inner city area and it is logical that this is where expertise should be based for EMHS. The north metropolitan area is larger than east and south metropolitan areas, with a more diverse population. In the north, we have small pockets of disadvantage that are not centralised around Sir Charles Gairdner Hospital (SCGH). NMHS also provides a large number of state-wide services, with services based in the broader metropolitan and country areas (e.g. Dental Health, PathWest and BreastScreen WA, etc.). Our services and expertise in homelessness are based in the community across the northern metropolitan area, particularly in mental health services, public health and dental health services. We do however support identifying champions within our service who could offer their expertise to other services and note that this is in addition to the Social Work led model of care at Sir Charles Gairdner hospital.	SMHS does not endorse this recommendation. SMHS will continue to partner with other organisations within (or external to) its catchment area to meet the needs of its homeless patients. SMHS provides a range of sub-acute services and the CoNeCT program in the community for vulnerable and complex patients. SMHS also works closely with existing partners and community service providers, including Aboriginal specific providers, to improve access to appropriate services to support homeless people to improve their health and wellbeing. The SMHS funded Freo Street Doctor service, a GP led mobile primary health service has expanded the number of clinics to a broader geographical area.	RPH recently partnered with the Homeless Healthcare General Practice to establish a Homeless Team (HT) based on the UK Pathway Model [(13)]. The HT, which commenced in 2016, aims to support homeless people during hospital admission, as well as improving discharge planning and providing better links to community services to improve the outcomes for homeless people. A report on the first 18 months of operation of the RPH HT[(15)] describes the profile of patients being supported by the HT. It also provides an overview of the model of care used by the HT and examines patient flow and patterns of contact with community services. Future reports will examine changes in health service utilisation by patients supported by the HT. The report of the first 18 months of the RPH Homeless Team operations is available here.		

3: That Health Service Boards should specifically include within their community engagement framework a process that ensures Aboriginal Elders within their catchment have input into service delivery and hospital culture.	Letter to be provided to HSB to consider.	Clinical Senate	July 2017	July 2017	**Endorsed -** NMHS provides a number of state and statewide services to Aboriginal people across all of Western Australia. NMHS have identified engagement with Aboriginal community Elders through endorsement of the NMHS Reconciliation Action Plan (RAP) and the Aboriginal Health and Wellbeing Framework 2015-2030. This engagement is achieved through the establishment of the NMHS Aboriginal Cultural Advisory Group (ACAG) who meet quarterly. The ACAG oversee Aboriginal cultural protocols, practices and principles aligned with Aboriginal cultural security across the service areas. A number of the ACAG members are representatives on the RAP committees across service delivery areas of NMHS. Cultural awareness and induction process for all NMHS staff covers recognition of trauma and loss and the acknowledgement of these in contemporary Aboriginal culture. All induction packages have been identified for review to ensure content provided is aligned and supports the importance Aboriginal place on extended family and country.	SMHS has an Aboriginal Community and Consumer Framework (ACCEF) that guides our employees in undertaking effective, culturally secure consultation of Aboriginal communities and consumers. The ACCEF aims to build strong partnerships between SMHS services and Aboriginal communities in order to better define and deliver the services required to best meet the health and well-being needs of Aboriginal people within SMHS.			