Great Chapel Street Medical Centre
Annual Report
2015-2016

A ONE STOP-SHOP MEDICAL CENTRE FOR HOMELESS PEOPLE IN WESTMINSTER

Allegory (or the Knight's Dream) Rapahel

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Introduction

By Dr Philip Reid

Our service is commissioned to meet the primary care needs of homeless people in Westminster, a group of people whose circumstances and lifestyle put them at high risk of mental and physical illness, injury, distress and premature death. The medical centre was opened in 1975 and has adapted and responded to the needs of those that present to us ever since. You will read in this report how each member of staff responds with their specialist skills to the problems we encounter. Also you will hear how we all work together to refine our responses to the difficult situations our patients find themselves in. I hope you will be struck by the passion and enthusiasm that everyone expresses for their work and the enthusiastic participation of our patients. We are proud that the Care Quality Commission recognised the responsiveness of the practice as 'outstanding'.

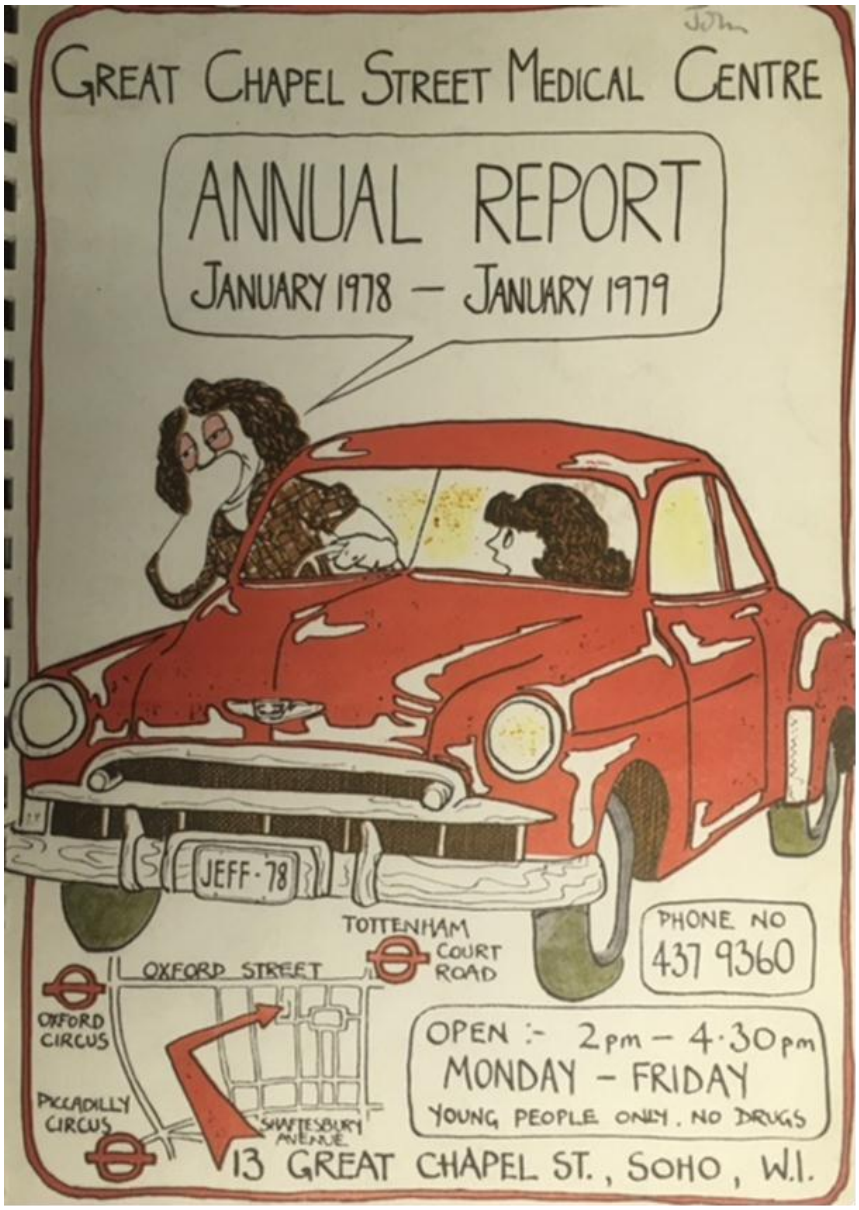
Although the staff who work at Great Chapel Street work for different organisations (Central and North West London Mental Health Trust, Central London Community Healthcare and the general practice itself) we very much see ourselves as working as a team with no artificial barriers between us. Our weekly multidisciplinary team meeting is an open, lively and interesting event. We also welcome members of outside teams who work with our patients and receive medical and nursing students.

We try to make access easy for our patients by running daily walk-in surgeries and providing several services concurrently. In this way our patients have for many years been able to access a GP, nurse, legal advice, mental health assessments, dentistry and podiatry at one site. More recently we have added the visiting outreach hepatitis clinic from Chelsea and Westminster Hepatology Department and the sexual health clinic from around the corner in Dean Street. We know every visit is precious and so we try to address as many needs as the patient and we can identify in each visit – time and patience permitting.
We have also reached out to those who do not come to us by providing nurse-led outreach services to a number of day centres, hostels and night shelters as well as joining the street teams to visit those people whose health is a concern.

With the support of Central London Clinical Commissioning Group we have developed a service (The intermediate Care Network) to accommodate patients when they are ill and cannot safely be treated whilst living rough. This excellent service gets patients better quicker and averts hospital admissions and is open to all patients on the sole basis of need. The stay of up to 6 weeks offers an opportunity to help people turn their lives around just when their vulnerability is most marked. We are deeply grateful that this service has been supported by the CCG at a time of significant spending restrictions.

In 30 years of working with homeless people in one capacity or another I remember above all that our patients are people. As you get to know them you also begin to understand why being homeless has come into their lives and how the label of 'homeless' is really incidental, although it does tell us something of their physical and mental state as an 'outsider'.
We are grateful to our patients for their fortitude in adversity and for their helpful feedback and support of our service.

Archives – annual report cover 1978-1979



A personal account of a former rough sleeper

Chris Ward (2005) playwright and patient

They say London can be lucky for some. You can get high on the vision and drunk on the dream. Robots work their painted gold. Homeless build houses with their souls. London is the sexy mother of all cities. We are the bastards of its forbidden glamour. Understudies snorting their lines for the role of a life-time. Easy fix tragedy. Super strength comedy. You take your pick. It's the best deal you are going to make. Human beings cry out for success stories and happy endings with the blind faith of a new religion. Except, that is when the one crucified in

this phoney, make believe, caring, sharing utopia happens to be you! So what happens when the shining future just around the corner turns into a dead end? You just get on with it. Go into survival mode or self destruct. Think about number one or give up the ghost. Haunting drop-ins and free hand-outs rankling chains on street corners for help. Trying to beg, borrow or steal back the identity taken so cruelly from us. Where do you go when those who think they know better say you don't deserve hope? Yes, they say London can be lucky for some.

Still, there is an oasis where you can take your rucksack of broken promises with others in the same boat. Where a shipwreck of despair can be rebuilt to face an ocean. Where you'll be safe and won't drown because hands will be here to keep you afloat. You have to delve into a Soho basement for Great Chapel Street Medical Centre. There should be a strip club sign of flashing neon instead of the soothing lake of a secret blue door. Here advice, assistance is free, on offer. Make use of it. It's open to everyone. Young and old. As well as experts who never judge you and deal with any problems you may have. There are your footsore fellow comrades of the street in the meeting room, all courage and jokes ready to share lives battle scars to help you live and fight another day. Both inputs are invaluable, the staff with their experience and vast knowledge of the situation we find ourselves in and those just like yourself who can share beliefs, opinions and aspirations to support each other. One thing you come out with at Great Chapel Street is that your life is moving gain to morrows on the horizon. That the world isn't just a cold and heartless place. There's a way forward with people who still care, a family you can actually choose, and that's not including the new mates you've met there. Together, that can be a strong combination and who knows maybe a winning one for once.

Patient Participation Group Representative (PPG) Contribution and Report

By Ms Christine Gill

“Then I found dignity
Down a back street in a grubby basement with a dodgy door buzzer
Sharing war stories, swapping survival tips, having a laugh
The humanity, empathy, trust, compassion, genuine support

What took me so long to get here?
I don’t know
Should have listened to rough sleepers’ rumours
They say
All that glitters in Soho is not creative gold
There’s medical gold - Great Chapel St Medical Centre
Thank you GCS, for the dignity.”

Patient Participation Group

Rough sleepers rave about GCS. But I came kicking and screaming. I just couldn’t see the point. Why would this place be any different? I was convinced no-one could help me. It took two years homeless and being at rock bottom to finally register. Actually, I had made a brief

visit 12 months earlier. Took a sneaky peak at the grimy waiting room, and walked out. Life was depressing enough without hanging around a basement that was probably going to make me feel even more depressed.

Big mistake. Two wasted homeless years that didn't need to happen. But, I only see that now. Before meeting the GCS team, I didn't know that I was unwell and on a slippery road to chronic rough sleeping. For rough sleepers, feeling unwell is a way of life. Housing was all I needed, and could manage my own health. But, I was wrong about that too. Housing is only part of the solution to helping the homeless.

The path off the streets is healthcare and having access to a trustworthy team that gets results. At GCS, I found a team passionate about helping the homeless in a non-judgemental, respectful and compassionate manner, and dedicated to improving its own services for the benefit of patients. Importantly, a system that places the health and wellbeing of individuals as a priority. A system that works. It saved my life.

I am proudly GCS's PPG. Some might argue that I'm in danger of becoming Evangelical in promoting GCS to other homeless. However, I take the PPG role seriously in the hope that it will help others, and raise awareness of GCS's critical services to all stakeholders.
I am very grateful to Nico for taking a 'leap of faith', and thankful to John for convincing me to ask Nico.

In July, I ran my first PPG meeting with 10 patients and a spread of fantastic healthy food (rare treat in homeless circles!). The group felt that their opinions would be valued, and comfortable providing constructive feedback in the areas where GCS might improve services.

To re-cap the three key outcomes 1) privacy, 2) dignity and 3) premises:

1. Privacy – mostly concerning the protection of personal disclosure at reception
2. Dignity – for example; assistance with personal care and appearance, cervical screening for women, improved dental care and a new hygienist service, paper bags for urine samples (especially for women), regular cleaning of toilets, disability access, among other issues
3. Premises – refurbish to create a more welcoming environment. The women in the group expressed concern about sharing a toilet with men, as this does not happen in shelters or day centres. Improve ventilation in the waiting room. Should GCS move to new premises there was unanimous agreement the 'spirit' of the place should be retained.

All patients agreed that the GCS team treat patients in a respectful and dignified manner, and patients feel dignified when coming to GCS. For this, the patients are most grateful.

Walk in Medical Centre
Accessible, non-judgmental, opportunistic, inclusive and multidisciplinary –

Working in partnership with the voluntary and statutory sectors to tackle homelessness and design services around the needs of homeless people

1. Who we are

We are a primary care medical service (we operate under an APMS contract) set up to provide enhanced specialist health services to the homeless adult population in Westminster. We have a multi-disciplinary team, with clinics being offered by general practitioners, practice nurse, substance use/mental health specialist, counsellor, podiatrist, dentist, psychiatrist, support workers (ICN), advice worker and advocacy/housing worker.

2. Our Services

Since its inception Great Chapel Street has been working towards a comprehensive and integrative way of tackling the needs of homeless people with an emphasis on access to services; reducing health inequality and being patient service-focused. We work inwards and outwards: inter-referring in–house to the appropriate specialist worker and or externally, referring to specialized agencies.

We are the first point of contact for a large number of homeless people in Westminster, offering a variety of services but mostly helping individuals to access the specific ones they need. One of our most valuable assets is our ability to engage with patients which is essential in their recovery and long term continuity of care. With a very skillful work-force we are able to offer ongoing support empowering individuals and sustaining them through the process of stabilization. We aim to ensure that patients will be appropriately supported to move-on into mainstream GP care.

3. The Team

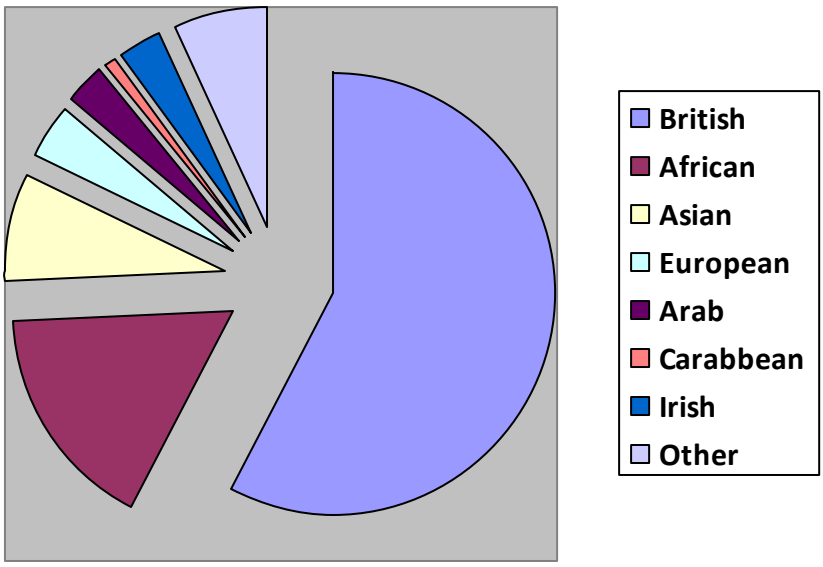
Our team is a multi-disciplinary team with professionals from different backgrounds and expertise.

The Client Group

The homeless adult population in Westminster, those who are rough-sleeping, are resident in a hostel or night shelter in Westminster, or in a boundary area. We also see refugees and failed asylum seekers in Westminster, irregular and undocumented migrants, people who have recently left institutions such as local authority care, the armed forces or prison and who are at risk of rough sleeping.

We have about 1200 registered patients, the majority of whom are male (ratio of male to female is 4:1) British citizens (circa 60%), in their 40's, with alcohol and substance misuse problems. They are rough sleepers, of no fixed abode or very insecure accommodation. Over 5000 consultations were carried out in 2015-16 of which nearly half were of GP time.

Ethnicity (Annual Report) in %



British citizens are overwhelmingly the majority of service users, followed by Africans and Asians.

General Practitioner Services

- Dr. Simon Ramsden, MA, MD, MB, BS, MRCP, MRCGP - Senior Physician.
- Dr. Philip Reid, BA (OXON), MB, BS, MRCP, MRCGP, DRCOG - General Practitioner.
- Dr. Natalie Miller, MBBS, Bsc, nMRCGP, DCH, DFSRH - General Practitioner.
- Dr. Hitesh Mistry - MBBS (LOND) MRCGP BSc. General Practitioner.

Psychiatric Services

- Dr. Sara Ketteley, Consultant Psychiatrist.

Dentistry

- Mr. Cyril Brazil, MSc - Dental Surgeon.
- Ms. Farah Askaridoust - Dental Nurse.

Nursing

- Ms. Maxine Radcliffe, BA (Hons) MSCPAPTN Nurse Practitioner.

- Ms. Maggie Fielder, DipHe Practice Nurse.

Substance Use/Mental Health Nursing Services

- Ms. Liz Abrahams, RMN, BA Hons, PGDip (Dual Diagnosis) (Applied Mental Health) NMP.

Counselling Services

- Mr. John Conolly UKCP Registered Psychoanalytic Psychotherapist **—** Lead Counsellor for the Westminster Homeless Health Team (HHT).

Podiatry

- Ms. Alison Gardiner BSc, MSCh, SRCh – Senior Podiatrist & Coordinator of Podiatry Services for Homeless and Vulnerable People Westminster PCT.

Social advocacy/Housing and Benefits Advice Services

- Mr. Nicolás Vial-Montero, Abogado, DipPJ, MA – Primary Health Care Manager.

Intermediate Care Network (ICN)

- Mr. Martin Skellern – team co-ordinator (currently on sick leave).
- Mr. Miles Davis – team co-ordinator (locum).
- Ms. Bernardine Flavious – support worker.
- Ms. Mandech Hussein – support worker.
- Mr. Melu Mekonnen – support worker.

Administration

- Mr. Bradley Redford - Practice Manager
- Mr. Serdar Arslan – Reception Manager
- Ms. Alison Marks - Receptionist and Secretary

4. Aims and Methodology

Aims

1. **To reduce social exclusion** – To improve access for homeless people to health services and act as a point of contact for linkage to mainstream medical and social services.

2. **To reduce health inequality** – To improve the health of the homeless population by recognising and addressing the multiple social and medical needs of our patient group

3. **To provide continuity of care for patients** – To offer a reliable and constant point of contact and follow through to those who lead a transient lifestyle

Methodology

1. Offering an integrated model of care with a full multi-disciplinary team. This includes, GP, nursing, psychiatry, substance use, dentistry, counselling, advisory and social care services.

2. Opportunistic engagement: Being able to inter-refer within the team. Multiple needs can be addressed in this way.

3. Having a no appointment system, to obtain engagement and promote compliance with treatment. Appointments are offered to those who want or need longer consultations.

4. Having a harm Minimisation Philosophy eg: inoculation with flu vaccine, pneumonia and hepatitis B vaccines and screening for hepatitis C and HIV. We also run a monthly sexual health clinic and hepatitis C treatment clinic.

5. Co-ordinating with voluntary and statutory services.

6. Pro-active approach towards hard to reach and patients presenting with chaotic and multiple need problems. Case management of complex needs patients to coordinate care and promote the most effective use of resources.

7. Patient centred service: we design services around the needs of the patients. Our hybrid nature: medical care and social care, allows us to go beyond the very essential interventions in medical care. For example, we can escort patients to services for specialist interventions; we facilitate them with clothing or a shower. We are a very flexible service adapted to a very complex client group.

8. Offering referrals and liaison into specialist services including Wytham Hall Supported Housing (fast track referral route), outreach and day centre services, Westminster Alcohol Service, (WAS), Joint Homeless Team (JHT), Westminster Drug Project, Turning Point, Westminster Drug Treatment Centre and Central & North West London Mental Health Services – i.e. the Assessment Team at the Gordon Hospital.

9. A non-judgemental attitude.

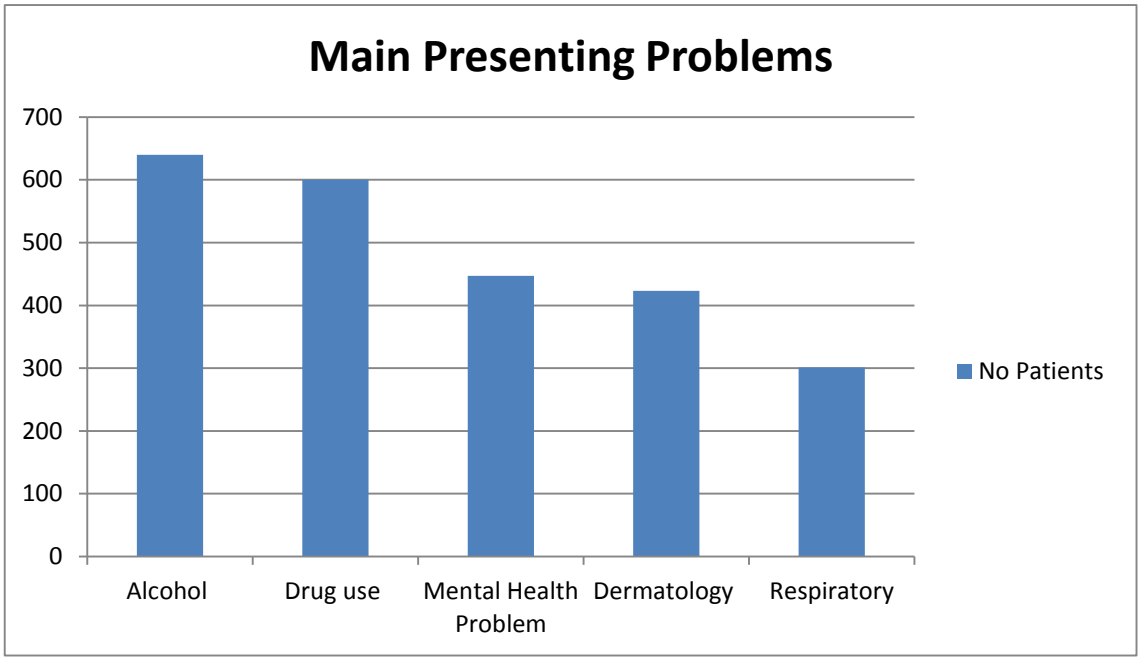
10. Practice MDT (Multidisciplinary Team Meetings) - Every Tuesday we hold practice meetings where we discuss complex cases. External agencies who may be involved with the case list are invited to attend.

11. Intermediate Care Network (ICN) – Health response service for rough sleepers who otherwise are likely to use A&E and be admitted to hospital. The service provides brief respite and support in hostel accommodation whilst meeting their complex needs.

- **Working with the voluntary and statutory sector**

We are part of CLCCG (Central London Clinical Commissioning Group). However, part of our success derives from the fact that we are able to provide specialist services because we are supported by different statutory organisations. The Central & North West London Mental

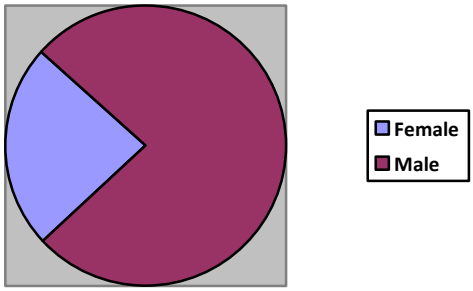
Health Trust provides a consultant psychiatrist, a Clinical Nurse Specialist and one administrator to the surgery, whilst Central London Community Healthcare, podiatry, dental and counselling, social advocacy and the reception manager. Our team works with other statutory as well as not for profit organisations, such as Community Mental Health Teams, Drug Dependency Units and Social Services; and voluntary bodies, such as housing providers, rehabilitation centres and drug counselling services.



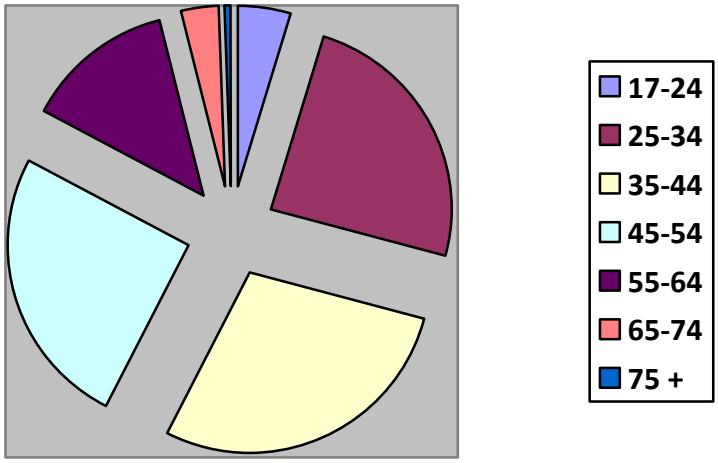
The above represent the main presenting problems. Patients may have a combination of some or all of these.

Gender (Annual Report)

Our current population is of 1200 patients where 76% are male and 23% female.

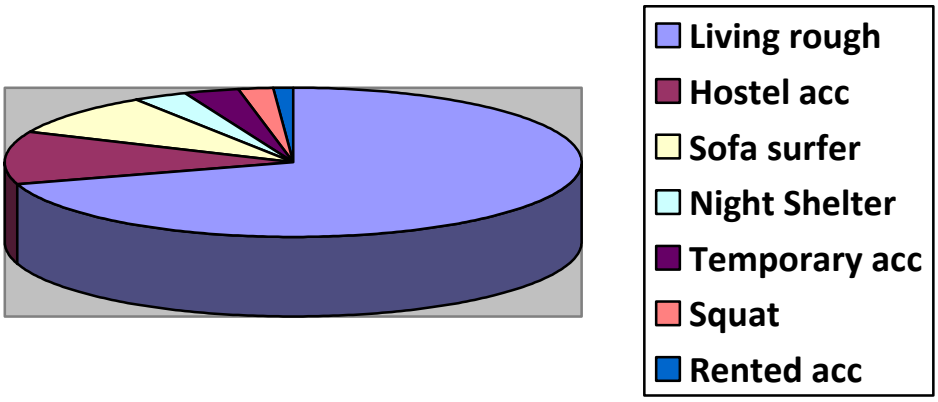


Age (Annual Report)



The majority of our patient's age range spans from 35 to 54 years old. According to most studies the life expectancy of the homeless population is 47.

Accommodation Report



Living rough and temporary or insecure accommodation remains the pattern.

5 Practice Manager's report

Bradley Redford – Practice Manager

GCS – ANNUAL REPORT – BRAD Submission

I have managed Great Chapel Street Medical Centre for the last three years. My responsibilities include ensuring the smooth day-to-day running of the practice, staff supervision and training, the maintenance and safety of the premises, attainment of the standards of service required by the Care Quality Commission (CQC) including responding to

complaints, ensuring that the GP contract we hold is delivered, managing finances and liaising with our many service partners, the central London Clinical Commissioning Group, the GP federation – Central London Healthcare and NHS England.

We have had one CQC inspection during my time and we achieved an outstanding score in patient responsiveness.

The Out of Hospital Services have been brought in over the last two years (see section on CLH below) and we have helped to set up, support and host the Intermediate Care Network as described elsewhere in the report.

Having come from a military background myself, I have been able to help some ex-servicemen who have become homeless. One particular former Fusilier had been homeless for a number of years but is now in secure accommodation in South London curtsey of a Service Charity.

I have had to manage the feedback, both positive and negative from patients . This has proved to be a time consuming and complex area, but never the less needs to be done in order to ensure our service learns and achieves best practice.

One of my more challenging tasks has been the management of incidents of aggression. We do what we can to prevent these from starting but inevitably there are occasions when tempers fray or patients are under the influence of alcohol or drugs, which disinhibit their behaviour. I have become more adept at managing these situations but we do have a zero tolerance policy and have to protect our staff and patients from danger. Where patients do overstep the mark we will discuss the case at our MDT meeting and decide on a course of action, which could be a warning letter and face-to-face meeting or referral for further care to the violent patient GP service. This is based in the Accident and Emergency department at St Mary's Hospital. We have referred a number of patients there, but only a very few have attended. Most patients simply attend another GP.

One measure that might well reduce incidents would be a move of premises or a substantial improvement to the existing surgery. This would permit the creation of a calmer, more relaxed and ultimately safer environment where, I feel, fewer incidents would be likely to occur.

CENTRAL LONDON HEALTHCARE (CLH)

I have been a Director and Chair of the Finance and Planning Committee of Central London Healthcare, which is a federation of the central London GP practices. This allows me to represent the voice of some of the most disadvantaged and vulnerable patients at a high level.

At CLH we represent practices in seeking to provide community services beyond the basic general practice contracts. This work has included the Out of Hospital (OOH) services which have made it much easier for patients to access a range of investigations and enhanced service within general practice and avoid having to attend hospital clinics. Examples include blood tests, electrocardiograms (ECG), spirometry to assess lung function and care planning for patients with the more complex medical histories . These services are available at Great Chapel Street.

CLH also runs the Whole Systems/Rapid Access services in central London. We have also been looking at ways to support the sustainability of practices, at a time of huge stress on general practice, through the GP Support Unit.

www.centrallondonhealthcare.co.uk

WYTHAM HALL

I have also held a joint management role at Wytham Hall. Great Chapel Street Medical Centre has a long established link with Wytham Hall as both were created by Dr David El Kabir and some of his junior doctors , some of whom remain partners, albeit in more senior roles now. Wytham Hall is a charity providing housing and support to homeless adults who have a connection to Westminster. They have 25 places spread over four different properties in North Westminster and offer low to medium level support. Many residents have a history of alcohol or drug problems and will need to be at a stage when they can maintain abstinence while resident at Wytham Hall.

Wytham Hall aims to understand residents' individual personality, background and health needs and offer appropriate personalised support.

The organisation is run by a dedicated and experienced staff team, which is in turn supervised by a Board of Directors.

As a small organisation they are able to offer a more personalised and consistent level of support. Each of the properties is different in character but all function most effectively when the residents develop supportive and positive relationships with each other.

Support staff work with residents in order to help in obtaining housing after leaving Wytham Hall. It should be noted that although Wytham Hall may be able to provide re-housing advice and referrals to suitable re-housing support organisations, it does not itself provide move-on accommodation.

One of my greatest pleasures has been seeing people, who came homeless and destitute go to Great Chapel Street, move into Wytham Hall and develop in skills and confidence before moving on to independent accommodation.

www.wythamhall.co.uk

6 General Practitioners and GP Report by Dr Natalie Miller

Dr Philip J Reid
BA (Oxford) MBBS (London 1989) MRCP DRCOG MRCGP

Dr Philip Reid trained at Oxford University and St Mary's Hospital in London. After qualification he trained in general medicine in west London hospitals before gaining the MRCP qualification. He then specialised in general practice obtaining the MRCGP qualification and DRCOG qualification in obstetrics and gynaecology.

Dr Simon S Ramsden MA (Oxford) MD MB BS (Hons. London 1984) MRCP (UK) MRCGP (Dist) - Senior Partner

Dr Ramsden trained at Oxford University and St Mary's Hospital Medical School. He won a number of scholarships and passed finals with distinctions in pathology and pharmacology. He trained in general medicine at London teaching hospitals obtaining the MRCP qualification before re-training in general practice. He passed the MRCGP exam with distinction. After joining the surgery in 1987 Dr Ramsden received a doctorate in medicine from London University for epidemiological work on epilepsy. Special interests include adult general medicine and child health.

Dr Hitesh Mistry BSc, MBBS (Lond), MRCGP

Dr Hitesh Mistry trained at King's College School of Medicine, London. He spent time publishing neuroscience research during an intercalated BSc in physiology, and obtained a 1st class honours degree. He trained in Adult medicine in London hospitals, before completing his specialist training in general practice at St Mary's Hospital in Paddington. He completed his MRCGP with Merit and has been working as a GP in the area for over 4 years.

Dr. Natalie Miller MBBS BSc NMRCGP DCH DFSRH

Dr Natalie Miller trained at Imperial College School of Medicine in London and graduated from there in 2006 with Honours in Surgery. During her training there she did an intercalated BSc degree in Psychology & Psychiatry and was involved in research at the Dangerous & Severe Personality Disorder Unit at Broadmoor Hospital. She completed her General Practice training in North West London gaining her MRCGP qualification alongside a Diploma in Child Health and a Diploma in Family Planning.

Dr Natalie Miller, General Practitioner.

Healthcare for a homeless population is unique. We are often a person's only non-emergency provider of healthcare. We see people who may be at the lowest point in their life, fleeing from trauma, in poverty, stuck in a cycle of institutional rejection; suffering and desperate. Their health is often not their priority. Yet with gentle engagement and encouragement, care and respect, we can help our patients to consider their health and make changes. Much of my role as a GP here is prevention and health promotion, whilst taking into account their social circumstances. We offer screening for common health conditions (diabetes, hypertension, hyperlipidaemia, chronic kidney disease, blood borne viruses etc) to all new patients or patients we haven't seen for more than a year.

We often see patients who have been unable to manage a chronic health condition due to their homelessness. They may present with poorly controlled diabetes or hypertension, physical effects of drug or alcohol misuse, smoking related lung problems and chronic skin infections. We support our patients to become knowledgeable about their condition, manage it appropriately and refer them as needed. We also support them in attending appointments in secondary care which can be challenging. Many of our patients are chaotic, unwell and have complex needs so we use Case Management systems for identifying their needs and coordinating their care.

As winter approaches, we see a rise in upper and lower respiratory tract infections, skin infections and worsening of many other chronic conditions. For many, sleeping rough leads to increased vulnerability to these infections, with crowded winter shelters and day centres contributing to the spread of airborne viruses. Recovery from these illnesses can be protracted and complications are common. Not prioritising their health means some of my patients present late with an illness and can be acutely and seriously ill.

We aim to improve access to specialist care for our patients. One way we do this is by providing a satellite hepatology clinic here monthly. A specialist hepatology nurse from Chelsea & Westminster hospital runs a clinic here for our patients with Hepatitis B and C. We engage the patient here, a place they know, can access and trust, before eventually transitioning them into secondary care for onward treatment. We also have excellent links with our local HIV and sexual health clinic and TB screening and treatment services. We offer as many in-house services as we can, including specialist mental health services, on-site phlebotomy and ECG, expert wound-care and spirometry.

Multidisciplinary team working is vital for these complex patients who usually have numerous co-morbidities. Other than our in-house team of mental health, podiatric and dental expertise, we run a weekly MDT. We invite colleagues from the Homeless Health Team, the local drug and alcohol teams, the Joint Homeless Team, and on occasion social services, palliative care teams, vulnerable women's midwives and many other allied services. We believe that visiting us here and seeing the work we do helps allied and secondary care services to appreciate the complex needs of our patients and gives them a broader understanding of why their needs may differ from other patient groups. We also host and attend numerous Professionals' Meetings and Case Conferences about complex patients, as a forum where all the professionals involved in the care of a patient can meet and discuss the patient's needs in an holistic way.

We are the patients' advocates in a healthcare system that can be daunting, complex and rife with barriers. We help them to prioritise their health, navigate the system and link up with the services they need. We believe our patients have the same right to access and receive healthcare as the housed population and aim to support them through that journey.

7 Practice Nurse

By Ms Maggie Fielder

Maggie Fielder and Maxine Radcliffe

Nursing at Great Chapel Street

I have been working at GCS for a while now and I have been really taken aback by the reasons that people become homeless, not only this but also the number of female patients that I encounter during my daily work that are refugees or fleeing domestic violence, experiencing a mental health condition or having to sex work just to have a roof over their head. The vulnerability and risk of exploitation are high, but I have found the character and human resilience of some of the people I encounter is amazing.

I have always been interested in health promotion and believe in equal access to health care for all. Our patients have so many other things to worry about, their bodies and brains are in survival mode and thinking about their health is often not top of their priority list. Becoming unwell, whilst homeless, can be and often is devastating. Therefore we work on 'prevention is better than cure' where we can. Being able to assess and directly inter-refer for immediate assistance within GCS for addictions/mental health nursing/dentistry/podiatry/counselling/psychiatry is a model I believe is exceedingly rare and valuable within any NHS setting, but essential amongst our clients who have no home and may not have the resources to attend many appointments within different settings.

Offering full health check-ups on registration and regular long term condition checks is an important part of my role. We are aware that being homeless puts you at greater risk of infectious diseases, so we always offer blood borne virus screening, and are aware we need to assess the risk of TB and other contagious diseases. Once the results of screening are back we can offer vaccinations to protect against Hepatitis A and B and Measles, Mumps and Rubella, alongside flu and the pneumonia vaccine in the winter. Referral to smoking cessation and exercise are also starting to become popular amongst our patients.

For patients registered on certain medications or with long term health conditions we offer the specialised out of hospital checks when they attend the surgery. We encourage and assist in

directing patients to other services such as podiatry and retinal screening for diabetics. This sometimes makes the appointment longer but it means that important issues are not missed.

As well as the Clinical room duties we are often involved in the multi-professional complex case management of our patients, such as those that have an infectious disease and other serious co-morbidities. More recently I have been managing some complex cases involving homeless pregnant women. This will often involve working sensitively with matters such as possible sexual and/or domestic violence/exploitation/trafficking, Female Genital Mutilation, religious and cultural beliefs, safeguarding, and immigration concerns. Referral to the appropriate services and support is essential to achieve a positive outcome for the women. These harder-to-reach and at-risk patients often do not present until quite late in their pregnancy. We have found targeting places such as the women's day centre in 'The Marylebone Project' are really helpful for early engagement with healthcare.

A very enjoyable part of my job in recent months has been clinically supporting the Integrated Care Network project. This project provides the basic needs for someone who is rough sleeping and unwell to avoid a hospital admission, and is something very much appreciated by the patients that have been through the pathway. My current role in this is to screen referrals and ensure that we are able to provide the intervention that will make a difference to this person's health by bringing them into a hostel bed Once in the pathway I will, with the patient, agree a plan of care to ensure that the health need is met whilst in the pathway. This may include referral and attendance to services and appointments with specialists within the practice or outside agencies. Through the journey I will see them to review the progress and alter care plans as necessary.

8 Psychiatry Report

Dr Sara Ketteley BM MRCPsych Consultant Psychiatrist in General Adult Psychiatry Honorary Senior Lecturer at Imperial College

‘A Man’s body and his mind, with the utmost reverence to
both I speak it, are exactly like a jerkin, and a jerkin’s lining; –
rumple the one – you rumple the other.’
(Laurence Sterne, from The Life and Opinions of Tristram Shandy, Gentleman, 1761) - quote taken from the Royal College of Psychiatrists Occasional Paper OP88 entitled Whole Person Care: From Rhetoric to Reality 2013

I am a General Adult Psychiatrist and have been a Consultant in Westminster since 2004. I started work in the Borough of Westminster as a junior doctor in psychiatry nearly 20 years ago.

I began working regularly at Great Chapel Street in September 2014. I work as a fully integrated member of the team at Great Chapel Street and provide mental health expertise during the weekly practice meetings. This is the key opportunity of the week to consider each person of concern as a whole, to consider their physical health problems and mental health problems together, along with their social care needs. This is innovative practice and affords excellent cross specialty learning opportunities and insights into how we might best provide safe care. I hold a 2 hour clinic in the mornings, followed by a 3 hour clinic in the afternoon. Most appointments are pre-booked, but on occasion I am also available to join the GPs or nurses in clinics as a way of removing the barriers to fast expert advice and as a way of encouraging patients to begin to think about how their mental health might be impacting on their physical health. I can also ask the GP or nurses to review someone urgently if I am concerned about the impact of their physical health on how they are feeling.

In the last year I offered 271 appointments. 82% of people attended for their appointments with me, despite often needing to plan ahead and remember the appointment. The Did Not Attend rate was about 18% and this is lower than the usual expected for a mental health

team. I think that the integrated working amongst the whole team has supported people to engage in their meetings with me.

My role is to work with patients to identify their challenges and to see if there is a way of understanding their difficulties within a mental health framework. I am able to make diagnoses, if helpful, and can recommend treatment plans to improve people's mental health, which often leads to improvements in physical health as well. An important intervention can be to try to illuminate a narrative that might make sense of why someone is finding it more difficult to cope than others and to think about how someone has come to be homeless. This can begin the journey of recovery, and with real hope that things can and will get better. Part of that process includes recognising how different people may respond under stress and to try to create an environment where individuals and staff can feel safe.

As well as focussing on difficulties, I strongly believe that it is important to focus on people's strengths and to support people to develop their resilience to stress. I often encourage people to access the CNWL Recovery College, or encourage them to get an exercise referral which are all part of improving overall wellbeing.

The core mental health team in the practice, including Liz Abrahams and John Connolly working together mean that we have no system barriers to beginning the journey to recovery and the work that John has developed in pre-treatment therapy is invaluable to our patient group to guide people to begin to engage in a safe therapeutic relationship.

I champion mental health and physical health parity and the importance of maintaining attention to mental health concerns at the forefront of delivery of care for people who are homeless by participating in some key programmes, including the round table on Homelessness and Mental Health at the Department of Health, the London Homeless Health Programme, and as part of the mental health expert group of the NHS England Homeless Health Services Programme Board.

9 Clinical Nurse Specialist Report

– By Liz Abrahams

I had heard about Great Chapel Street Medical Centre many years before being afforded the opportunity to work here.

Great Chapel Street is legendary. A Beacon of excellence within Homeless Healthcare Provision and I wouldn't swop the opportunities afforded me over the past four years – allowing me to work and develop in a field (mental health, addiction, homelessness) that has drawn me throughout my professional life.
Writing this report is tinged with sadness as I am coming to the end of my time with the Great Chapel Street Team. For some of my colleagues the work is perennial – a lifetime vocation. For me it has been for a Season. One I shall never forget.

We are a closely knit team. I often joke that I spend more time with colleagues than I do with my own family. The close working relationship means we develop strong familiar bonds. I would say we know one another pretty well. I have probably fallen out with each and every one –and made up with them even more quickly. Like any family situation the sea is not always calm. However it is the way the Staff work symbiotically –day in-day out– quite literally – without appointments – providing entirely open access which has allowed us to create the magic and rarely mayhem that is Great Chapel Street.

We offer a truly holistic Service: following registration, new patients are given the opportunity to pass through each of our doors –addressing physical health, mental health, counselling, dental health, foot health, social, legal and economic issues– we often have joint consultations.

Very soon after starting work at Great Chapel Street I bought a world map, stuck it on my wall and began noting the various places people who came to see me originated from. To date there are near to one hundred stickers marking various countries. The world walks through the door at Great Chapel Street and somehow we are prepared.

How is this achieved? Initially I was overwhelmed with the complexity, pain and suffering. I had spent years with my head in theory books –but theory alone couldn't prepare me for the extremity of need experienced by people whose lives had been turned upside down as a result perhaps of war, genocide, incest, bereavement, abandonment all manner of atrocity.

I learnt early on that things needed to be done differently if I were to have any hope of making a positive difference. The people I work with have keen bull shit radars and whether I liked it or not I would need to bring my true self to the table –working 'with' rather than doing things 'to' people. For this to happen I needed to be open –when appropriate disclosing my own vulnerabilities, mental health history and personal experience of homelessness.

I am often asked what mental health models I use, what treatment approaches I favour. In truth, I have reached less for the text book and more for the tea cup over recent years. I feel Carl Rogers (humanistic psychologist 1902-1987) was right when he spoke about true healing coming from a positive relationship between people working together. He said for a person to grow, they needed an environment that provides genuineness (openness and self-disclosure) and acceptance with unconditional positive regard and empathy.

For anyone not familiar with the geography of Great Chapel Street Medical Centre –speaking tongue in cheek, it's perhaps hard to see how anything could grow down here. We are housed in a basement with no natural light. Looking in, we are a no frills, pretty shabby affair. The quality, kindness, humour and commitment of Colleagues I have worked with more than counteract the physical shell.

Over the past four years a few of my rough edges have been knocked off. I have made some clunking mistakes but had the good fortune to work with a group of people –clients, colleagues both at Great Chapel Street and Central and North West London NHS Foundation Trust who have allowed me a generous dollop of forgiveness and acceptance.

I would like to express sincere gratitude to every person I have met and who has been part of this journey with me. It's been a blast.

10 Counselling Report

By Mr. John Conolly – Lead Counsellor for the Homeless Health Team

As ever, as well as consolidation, this year has been one of innovation and change for the Counselling Service:
1- It has actively developed the 'Pre-treatment Therapy' model of caring for multiply excluded homeless people. This approach takes into account the traumatic history of many homeless people, their chaotic circumstances, proneness to crisis, and their dysfunctional survival strategies. Westminster City Council has formally adopted this approach as part of its strategy on homelessness, and is looking at funding its roll out throughout the borough.

2. On average the service has seen 20 patients a week, some 960 counselling sessions a year.

3. Speakers from the service have delivered presentations at the:
- 4th and 5th International Conferences on Homelessness and Exclusion Health, March 2015, and March 2016, London,
- Master Class Series on Social Exclusion, Royal College of Physicians, Dublin, September 2016
- DOH Round Table Discussion on Homeless Health, September 2016
- Social Exclusion Conference, Paris, October 2016

4. The service is contributing chapters to two publications:
- 'Social Exclusion, Compound Trauma and Recovery', Ed, Peter Cockersell, Jessica Kingsley Publishers.
- ' Cross-cultural Dialogue on Homelessness: From Pretreatment Strategies to Psychologically Informed Environments', Ed, Jay. S., Levy, LHP Inc. Publishers.

5. The service also delivers consultancy and reflective practice sessions for:
- 'Primary Care Plus',

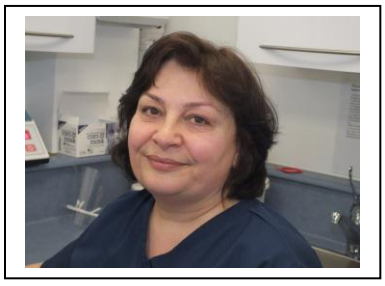
- ‘Central London Health’,
- CLCH NHS Trust Homeless Health Nursing Service.

6. The service was a founding member of the Westminster Complex Personality Network (2010), and continues to chair this valuable cross sector learning, discussion and information exchange forum, which includes people with lived experience, and is presently administered by Westminster City Council.
7. Looking to the future the service is establishing new Support & discussion groups for homeless people:

i. Womens’ only support Group – Marylebone Project – November 2016
ii. Anger Support & Discussion Group – The Passage Day Centre.
This in addition to the group at CsTM.

11 Dentistry Report

Dr. Cyril Brazil BDS MSc and Ms. Farah Askaridoust BSc Registered Dental Nurse



Dental care remains a most important part of the overall health care that The GCS Medical Centre provides. Dental disease still remains the most common disease affecting mankind. Homeless people suffer worse oral health than the general population. Coupled with the problems of access to dental care that the homeless experience, makes our clinic all the more essential.

The demographics of our patients continues to change with a preponderance of homeless East European men, some female asylum seekers from Africa and some British residents. Many patients have very little or no English at all. Most have had little exposure to oral health care except extractions. They have very destroyed dentitions which used to be commonplace in the UK in Victorian times but is now rarely seen in British people. Treatment needs are very high. Treatment plans usually involve extensive invasive oral surgery, often full clearances of teeth followed by full dentures.

All treatment is provided under NHS regulations. Our Community Dental Service, which runs this clinic, has wisely and generously chosen not to charge the dental NHS fees to any patients who are not exempt. The laboratory charges alone are very high.

Many patients’ expectations are unrealistic and can be very challenging. We offer affordable, viable treatment plans appropriate to NHS dental care. Crowns and bridgework and much root canal work are not appropriate on very neglected dentitions with little oral hygiene input on a

first course of treatment. Dental implants are not provided on the NHS but many patients expect such treatment to be free.

Strangely there is a very high failure rate of new patients who make appointments but never turn up. However a good 50% of patients of those who do attend continue with treatment including fillings, surgical extractions and the fitting of dentures, which can take up to nine months to complete, assuming all appointments are kept. Some patients only want episodic care; that is attention to the immediate problem, but do not wish to address any other dental problems that they may have. Sadly there is a high failure rate of patients missing appointments or never completing their treatment. We have many unfitted dentures and even bridges!

However, all is not gloom. Most patients' reason for a first visit is pain. Usually a broken down infected tooth or teeth, which require immediate removal. We endeavour to see almost every patient in pain on the same day. However, the clinic only works two days per week. This is usually carried out on the same visit. So most patients have their urgent problem addressed without delay be it an extraction, re-cementing a crown or temporary filling placement.

Having an in house dental service on the same premises as GCS Medical Centre is, in my view, essential to full health care for the homeless. Referring our patients' elsewhere with dental problems is often unsuccessful and patients do not attend an unfamiliar location at a later date.

From a personal point of view I have now retired at the age of 70. I have worked at this clinic looking after the homeless for 20 years. It has been fulfilling work helping the less fortunate in society. However, we do not work in isolation. I have had a most wonderful nurse, Farah, who has looked after the patients and myself very well. It is the ethos of GCS Medical Centres', the holistic whole team approach of the doctors, nurses, councillors and therapists. It would be very difficult to run the dental clinic in isolation. I do hope that this essential dental service survives the austerity measures that the NHS is now imposing.

12 Podiatry Report

Ms. Alison Gardiner
BSc (Podiatric Medicine), HCPC Reg. MChS

Specialist Podiatrist for Homeless and Vulnerable People
Central London Community Healthcare.

The weekly easy access drop in podiatry clinic at Great Chapel Street sees a wide variety of foot problems ranging from painful ingrowing toenails and corns (that patients have often tried to treat themselves for years with razor blades) to fungal infections of nails and skin, blisters, painful verrucae and trench foot.

All patients receive a full foot assessment , including vascular assessment with Doppler and neurological assessment.

Biomechanical foot problems (heel, forefoot, arch, ankle and knee pain) are also treated with biomechanical assessment, and provision of orthotics. As the podiatrist based at Great Chapel Street works under the CLCH mainstream podiatry service, there are close links with the mainstream Specialist MSK podiatrists for assistance with more complex cases.

Treatment of their foot condition will be accompanied by advice on general and specific foot care, taking their current circumstances into account (ie rough sleeping or hostel resident).

Where appropriatriate, (eg. hostel resident and in need of follow up care) the patient is referred to the mainstream podiatry service at their local clinic. Often patients will need support to attend appointments rather than attend a drop in session, so this will be set up with their hostel keyworker.

Diabetic patients at the surgery are specifically targeted for diabetic annual foot checks in order to reduce and prevent avoidable severe foot complications (infection, ulceration, gangrene and amputation). There are close links with the CLCH diabetic specialist podiatrists where input is needed with more complex cases.

If surgery is needed for ingrowing toenails, this can be arranged via the mainstream CLCH podiatry service at our operating theatre in a local clinic.

Referrals for podiatric surgery can also be made to the CLCH podiatry service's Podiatric Surgeon. Recently a young man in a hostel with severe foot deformities, (caused by wearing

poor fitting shoes as a child and resulting painful corns and calluses) has had surgery which will allow him in future to work in the construction industry as he wishes.

Podiatry undergraduate students from East London University frequently shadow the podiatry session. This helps to give them an insight into the care of the most vulnerable members of the community. New CLCH mainstream podiatry service employees can also shadow the service as part of their induction. This helps to give them insight into working successfully with vulnerable community residents with mental health, drug, alcohol issues and learning difficulties and improve the effectiveness of their work in this area.

The surgery stocks a small amount of second hand shoes, trainers and socks that can be issued to patients whose current footwear is exacerabating their foot problem.

13 Primary Health Care Manager's Report

Nicolás Vial-Montero

Mr. Vial-Montero is a Spanish-trained lawyer, who initially qualified with the Barcelona Bar Association before moving to the UK. Licentiate in Law by the Barcelona University in 1990. Specialised areas of practice include Intellectual property and commercial contracts but in the past few years he has focused his work on vulnerable people dealing with housing, immigration, welfare rights and debts problems. He has a special interest in criminology and mental health problems.

Great Chapel Street offers a combination of health and social care services for homeless people in Westminster. We work with the most vulnerable and often invisible people in our society. Whether because they are forced into social exclusion or self-induced exile in the form of mental and emotional reclusion. In most cases, there is always something else to uncover, layers of needs and problems which can only be ascertained in time after the initial consultation.

Our clients come from a variety of walks of life. People that have experienced trauma in early life or later in adulthood. The marginalised and the voiceless that unfortunately have detached themselves from society or simply have fallen off of the radar, embracing a new homeless identity, which then becomes very difficult to disassociate from.

The variety of presenting problems(physical, mental, social) require a variety of solutions, joint work and imaginative approaches due to the challenges and complexities in finding

appropriate and sustainable answers to such deep rooted problems. The co-morbid pathologies involved mirror themselves in multiple social problems, such as housing, welfare, debt, immigration, isolation, etc. Great Chapel Street responds to these multiple areas of need with a multidisciplinary team approach solely dedicated to this client group and focusing in building strategies of support around each individual.

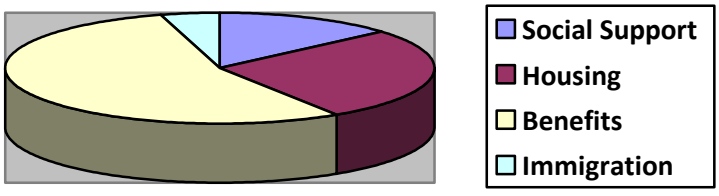
My work is to contribute to those strategies, incorporating support and advice to the social and legal aspects of need. My advocacy work includes helping clients to access and to overcome the barriers of eligibility for services, advocating for their entitlements, benefits applications, representations and appeals, housing advice, helping in maximising income and homelessness prevention (assisting when people are about to lose their homes) as well as liaising with external organisations where it is required to fulfil such strategies.

Main areas of advice:

From 428 consultations in y/e 2015/16 –

Benefits, Housing, Social Support and Immigration.

Immigration advice helps with clarifying benefits, housing and medical secondary care options. Helping people to obtain eligibility is the first step towards any action plan of recovery. **Benefits** are the basis for other benefits. With benefits clients can access housing and pay for their daily living. **Housing**, undoubtedly helps people to settle, obtain treatment and reincorporate themselves into their communities. **Our social and advice work is instrumental to improving health and wellbeing**. The advice also tackles homelessness by preventing homelessness. Helping with possession proceedings, stopping evictions, helping to reinstate benefits and maximising income, so clients can sustain both accommodation and food. The advice is also about accessing housing through the statutory homelessness route or via the rough sleeper's initiative and in collaboration with the Local Authority and their homelessness strategy.



Benefits advice has increased dramatically in the last few years due to the complexities of the benefits system and policy of sanctions. This has been manifested in a large number of representations before the Appeal Tribunal and on-going support when benefits have been discontinued. Often benefits applications have to wait for a court hearing in order to be granted. Social support remains an area of vital importance in navigating institutions and helping to linked up patients with mainstream services.

Housing remains a huge problem (shortage of social housing in London, the end of security of tenure, putting vulnerable people at risk of becoming homeless again) coupled with the historical legal and policy restrictions of accessing accommodation by the homeless people with non-fixed abode. This is due to their transience (lack of local connection). In the past few years, difficulties have been exacerbated in the light of benefits reforms, financial austerity and unnecessary administrative errors in addition to a punitive approach by the Department of Work and Pensions – policy of sanctions, bedroom tax, and reduction on housing benefit entitlements (incorporation of caps). Finally, restrictions in eligibility for benefits to European migrants who may have lost their rights to Job Seekers Allowance due to habitual residency issues often linked to unemployment, more restrictive reforms, and the lack of evidence proving status.

Our collective work (strategic care packages) is about connecting the loose ends, bridging the gaps and responding to the challenges with a great deal of empathy, engagement, dignity and humanity.

We can safely say that the setting at Great Chapel Street in practice works like a PIE – a Psychologically Informed Environment, in our approach to service delivery: as one united and integrated force tackling the needs of our patients. We can also safely say that we are an organic, as evolving, psychologically minded organisation with an established reflective practice.

From a Patient Participation Group held in July of 2016, one of the topics that kept coming up in the meeting was the idea of dignity. When we asked the group about what would be useful to have in a new building if hypothetically we were to move premises, the overwhelming response was to bring to the new setting the spirit of Great Chapel Street: the humanity and empathy of its staff. The perception was that the team dignifies the centre and users felt dignified and humanely treated when coming to Great Chapel Street.

A good example of our approach to service delivery was outlined in the CQC (2015) report when looking at responsiveness. “The practice is rated as outstanding for providing responsive services. There was a proactive approach to understanding the needs of the practice population and to deliver care in a way that meets these needs and promotes equality.”

The picture in Westminster

2,857 people were seen rough sleeping in the borough in 2015/16. This represents an 11% increase when compared to 2014/15. A staggering 47% from central and eastern European countries compared with 33% of UK citizens. (CHAIN annual report April 2015-March 2016).

Undoubtedly, both national and international circumstances have helped to shape the current picture of homelessness in our streets. The refugee crisis (middle east, Calais), the internal (and international) downturn in the economy and on-going austerity policies across the board (including our own CLCCG where it has to find 11 million of efficiency savings) have reduced the capacity to respond to an ever increasing need for services and welfare support. Aggravated by changes (restrictions) in benefits entitlements to migrants and specifically individuals coming from the EEA who often fail the test of residency required for state support such as for accessing welfare benefits and secondary care, e.g. residential detox and rehab. This scenario has a consequential knock on effect in our service. There is more demand and fewer resources. People left unaided because of the cuts and other restrictions (e.g. the abolition of refugee grants that used to assist in resettling new refugees in the community). The slow introduction of Universal credits (One payment for Income-based Jobseeker's Allowance, Income-related Employment and Support Allowance, Income Support, Child Tax Credit, Working Tax Credit, Housing Benefit) across the country (should be fully introduced by 2018) and its administrative problems leaving people in hardship. The main cause of difficulty is a built-in delay to universal credit which requires claimants to wait at least 42 days before receiving a benefit payment. This has left some claimants without income, falling into debt, stressed and putting their homes at risk.
The Brexit decision last June will possibly affect the sector even further, as European migration might be curtailed and eligibility for accessing public services too. It is possible that Europeans already resident in the UK will maintain certain rights but it is also possible that their future rights will be restricted (e.g. accessing sickness and employment related benefits).

What is needed?

More investment is necessary. More affordable homes available to vulnerable people, a benefits system that doesn't punish individuals (sanctions, cuts) but in fact stimulates change and stability, more support and assistance to individuals threatened with homelessness and at risk of repossessions (inclusive preventative legislation like in Wales), investment in education and drug programmes that help rehabilitation and reinsertion in the community. Changing the rules of local connection and introducing more collaborative approaches between local authorities across the country. A pan-london homelessness strategy where there is a network of organisations complementing each other and not being distracted by fighting for the same pot of funding.

14 Reception Report


Mr Serdar Arslan and Ms. Alison Marks – Mental Health Administrator

By Serdar Arslan – Reception Manager
Legal Studies (Dip) LLB (Hons) Grad Dip (Psych)

There is no doubt the Brexit referendum will impact the UK politics and economy, but will also hit the NHS and voluntary services working with vulnerable and socially excluded people, such as migrants and the homeless. As a nation, UK is currently going through difficult and uncertainty times, with low morale in the job market, lack of investment and confidence in affordable housing and cuts in welfare benefits have all contributed to the current picture of instability.

During this period of political and social turmoil, Great Chapel Street Medical Centre will continue to work with multi-agencies and partners to provide primary care for homeless people. Our mission, core principles and moral responsibility guides us to support homeless people, encourage and engage them with services and treatments.

We have been working closely with Groundswell. Peer advocates have played a vital role to support homeless people to attend appointments and help with local registration and maintain engagement and contact. The valuable input from Groundswell will ensure less missed appointments and save costs and resources for the NHS.

We have made use of the language-line to support vulnerable people. This has helped patients with language barriers to address their health and social problems. We also work with local chemists regarding prescription and help people with no recourse to public funds. Our engagement and communication with local services has made a difference to our patients care and our working relationships.

My role has changed over the years, with more emphasis on engagement and support. Since our migration to System One, we have been working and sharing data with Homeless Health Team to manage care for homeless people. System One has helped us to retrieve medical records more quickly via GP2GP route.

We will continue to offer help and support for those in need and it is my duty to ensure that happens. We are always keen to get patients actively involved in decision-making on a range of issues. For example, we offer Friends and Family surveys on a monthly basis to document feedbacks from patients.

As a practice, we have touched on many lives with traumatic backgrounds and complex history. We take them at a stage of crisis and trauma through a transition period of stability and eventually full recovery.

Great Chapel Street Medical Centre will continue to rebuild peoples live and integrated vulnerable people back to society with more hope and better future.

Ben Sackey – Cleane

Our special thanks to Ben who makes sure our centre is Spotless.

15 Intermediate Care Network (ICN)
By Mr Miles Davis

From left to right: Mandech Hussein, Miles Davis, Bernardine Flavious and Melu Mekonnen (front).

The Intermediate Care Network or ICN service (it wouldn't be the NHS if we didn't have a good acronym!) is commissioned by the Central London Clinical Commissioning Group (CL CCG), run by Hestia Housing and Support in partnership with Westminster City Council (WCC). It is a health response to rough sleepers in Westminster presenting to specialist services with health conditions which are difficult to treat successfully whilst patients remain on the streets and are likely to result in hospital admissions. We are an innovative health response to a group of patients who present with complex histories and often struggle to conform or co-operate in more usual treatment plans.

In simple terms the service has two functions. Firstly, to facilitate treatment interventions by placing in temporary accommodation rough sleepers, who have health conditions that would otherwise lead to hospital admissions if they remained on the street.

Secondly, to provide a professional network for clinicians and professionals working with homeless people on the street and in supported accommodation pathways in Westminster. This enables an integrated approach to the interventions of workers across professions and the sharing of good practice with the use of case studies.

We are a small team based at Great Chapel Street, with a co-ordinator and 2 (FTE) In-Reach Workers. We have a lead nurse from the practice and clinical leads in both Great Chapel Street and Dr Hickey's practice. The ICN team rely on a network of partners within the health service; the Homeless Health team, the Joint Homelessness Team and discharge teams in central London hospitals. Crucially, we have a strong partnership with hostels in Westminster run by the voluntary sector and work closely with colleagues in local day centres and street outreach teams.

When a patient is identified as a potential client, either from within the two homeless GP's practices or referred to us by other professionals in the sector, the clinical lead makes an assessment of treatment needs against ICN criteria, and they then decided to offer our assistance and establish with the patient clear clinical goals for the intervention.

The ICN team will initially work with the patient to place them in one of the beds we have available. The In-Reach workers will then support patients to ensure they fulfil the treatment goals but also identify next steps for the patient's potential housing. Our ultimate aim is to ensure the treatment is successful and each patient has a route into more long lasting accommodation.

In the first six months of this year the team has worked with 57 individuals in need of both treatment for serious health conditions and shelter. In the last quarter, we have had 21 patients. 3 are still with us and 18 have achieved their health goals. Of those 15 have been assisted to move to other accommodation rather than return to the street.

I think the best way to describe the ICN is through the successes our patients have achieved. To this end, I have described two such individuals (anonymised).

The first gentleman came to us having been living on the street for over a year. He had been the victim of an assault following the referendum result and suffered significant injuries. Whilst with ICN, he was able to get the treatment and rest to recover from his injuries and avoid the major complications that would almost inevitably occurred had he remained on the streets. The team also managed to secure his passport and he himself made great steps in his drinking. By the end, he left us to go to work and support himself.

The second gentleman had been street homeless for over ten years and, though he was well known to Great Chapel Street he had not ever wanted to come indoors. He had a long term substance use history and a significantly infected wound – I remember one clinician describing it as 'auto-amputating'! We put him into a bed and persuaded him to go on a script. He had a rocky first couple of weeks and a couple of difficulties with the hostel initially. However, by the time he left us his wound had healed significantly and he remained drug free for the time he was with us. I had an update last week and he remains drug free and is in accommodation.

PUBLICATIONS

Great Chapel Street Medical Centre
El Kabir D J
British Medical Journal 1982 284:480-81

Tuberculosis among the Central London Single Homeless
Ramsden S S, Baur S, El Kabir D J
Journal of the Royal College of Physicians 1988 22:I6-17

Medical Care of the Homeless
Ramsden S S, Royal College of General Practitioners Members'Reference Book 1989: 362-63

A Mobile Surgery for Single Homeless People in London
Ramsden S S, Nyiri P, Bridgewater J, El Kabir D J
British Medical Journal 1989 298:3 72- 74

St. Peter's and the Homeless
El Kabir D J, St. Peter's College Record 1990

Mentally Disordered Homeless Offenders - diversion from custody
Joseph P L A, Bridgewater J, Ramsden S S, El Kabir D J
Psychiatric Bulletin 1990 14:2 70- 71

A Psychiatric Clinic for the Homeless in a Primary Caie Setting in Inner London
Joseph P L A, Bridgewater J, Ramsden S S, El Kabir D J
Psychiatric Bulletin 1990 14:270-71

Approaches to the Medical Care of Homeless People in Central London
Ramsden S S
In: Smith S J, Knill-Jones R and McGuckin A (eds): "Housingfor Health " 1991
Longman Group.

Quelques Observations sur les Sans-Abris
El Kabir D J
Paris, Les Tempes Modernes 567. 1993

A Pragmatic Approach to the Care of the Single Homeless: its implications in terms of human resources.
El Kabir D J Ramsden S S
Dimensions of Community Mental Health Care (ed) Weller M and Mu@en M WB Saunders 1993.

Homelessness, Doctors, le Grand Siecle and St. Catherine's
El Kabir D J, St. Catharine's College Society Magazine 1992
Diversion Revisited

Joseph P
Journal of Forensic Psychiatry 1992 3:219

Non-custodial Treatment: can psychopaths be treated in the community?
Joseph P
Criminal Behaviour and Mental Health 1992 2:192-200

Psychiatric Assessment at the Magistratels Court
Joseph P
Report commissioned by the Home Office and Department of Health 1992
British Journal of Psychiatry 1994 164: 722-24

Psychiatric Court Clinics in the United States
Joseph P
Psychiatric Bulletin 1992 16:557-560

The Perception of Emotion by Schizophrenic Patients
Joseph P, Sturgeon D, Leff J
British Journal of psychiatry 1992 161: 603-609

Psychiatric Morbidity and Substance Abuse among Residents of a Cold Weather Shelter
Reed A, Rainsden S, Marshall J, Ball J, O'Brien J, Flynn A, Elton N, El Kabir D
Joseph P.

'Accessing Primary Care for Homeless People
Field, S (2000) Connect

Meaningful Occupation
Field, S (2000) Connect

Interview with homelessness Tsar
Field S, Mental Health OT Vol 5. Issue 3 p 4-7

Filling the Void,
Field S, Therapy Weekly (3rd August 2000)

Nursing and Homelessness: A review of nursing and the provision of health care for the homeless within the London Region
London Standing Conference for Nurses, Midwives, and Health Visitors, Nursing and Homeless Group (2000)

Meaningful Occupation and Homelessness: Conference report
Hughes, G, Field S, (2000)