Pathway and the Faculty for Homeless & Inclusion Health

Alex Bax, Chief Executive, Pathway
Social gradient in preventable emergency hospitalisation

Health inequality and the a&e crisis, Centre for Health Economics, University of York
The Chronic Morbidity Cliff

Asthma

Stroke

Heart disease

Epilepsy

Age adjusted relative risk (95% CI)

IMD 1  IMD 2  IMD 3  IMD 4  IMD 5  IMD >5

IMD 1  IMD 2  IMD 3  IMD 4  IMD 5  IMD >5

IMD 1  IMD 2  IMD 3  IMD 4  IMD 5  IMD >5

IMD 1  IMD 2  IMD 3  IMD 4  IMD 5  IMD >5

Story A. Slopes and cliffs in health inequalities: comparative morbidity of housed and homeless people. The Lancet, Volume 382, Page S93, 29 November 2013
Independent risk factor for mortality

- Homeless patients (including hostel dwellers) admitted to hospital in Glasgow with a drug related problem are 7 times more likely to die over the next 5 years than housed patients with the same drug related reason for admission.

Homelessness and health

• Chronic homelessness is characterised by tri-morbidity
• Physical ill-health with mental ill-health and substance misuse
• Childhood trauma followed by a life course full of adverse events

• Homeless people consume 4 times as much hospital care
• Homeless people cost the NHS eight times as much in secondary care
Figure 1: Overlap of SMD disadvantage domains, England, 2010/11

We are spending a fortune and outcomes are appalling

• The average age of death for homeless people is just 47 years


• Tri-morbidity characterises homeless acute admissions – physical ill health with mental ill health and drug and/or alcohol abuse
University College London Hospital
Pathway hospital team
Simple, replicable, care coordination model

• Think homeless! 80% of patients referred with 48 hours of admission
• Homeless nurse practitioner with care navigator supports patient and begins care plan
• Regular GP led ward rounds coordinate care, advocate for patient and liaise with community agencies
• Weekly multi-agency care planning meetings
Key ingredient – clinical engagement

• Housing worker alone is useful, but risks isolation, incomplete assessments, lack of holistic overview

• Complex and multi-faceted problems require coordinated multi-agency responses

• Team’s must care about the patients
What is different about this approach?

• Vertical integration – specialist primary care reaching in to the hospital to coordinate care
• Horizontal integration – care coordinated across physical ill health, mental ill health, substance misuse, social care, housing & voluntary sector within the hospital and out into the community
Logic model example – SLAM Pathway team at KHP
2x mental health practitioners

0.2 GP

1.0 housing worker

0.2 integration lead

inputs

case work in / out hospital

see, assess and plan

reconnection with other services

advocacy to other services

ward-based primary care asst & treatment

advice on how to negotiate borough housing services

legal advice

activities

multiple case-working contacts

completed assts and plans

client sees other services

service to service contacts

new GP registrations

completed primary care assessments

preparing documents & taking people to see housing services

rest of team are given legal advice

outputs

reduced readmissions and reduced bed days

reduced emergency presentations

increased use of community health services

GPs better aware of health needs

rehousing and housing stability

outcome s

specific way of recording in PJS

specific way of recording in PJS

specific way of recording in PJS

specific way of recording in PJS

specific way of recording in PJS

specific way of recording in PJS
A new pathway for homeless patients

- Attending St Thomas', Guy's or King's

KHP Pathway Homeless Team
- **GSTT base:**
  - GP 0.4 wte; RN 2 wte; OT 1wte; HSW 3 wte; Admin 1wte
- **KCH base:**
  - GP 0.4 wte; MHP 1 wte; SW 0.4wte; HSW 1 wte

Integrated, multi-professional assistance
- Practical assistance
- Health review
- Housing
- Reconnections
- Frequent attender work
- Safeguarding

Community support
- Outreach teams
- Day centres
- Homeless health teams
- GP practices

Groundswell
- Peer advocate support with physical health appointments and GP registration
Pathway – what is the evidence?
Quality – UCLH feedback

• You were the only ones that felt my life was worth saving - I am now back with the family I have not seen for 10 years
• I’ve never stayed in hospital as long as this (2wks), I trust you, that’s why I am staying
• The change is tangible, ...full confidence that contacting the team will produce results
• Joint working with housing options has greatly improved customer care
• ..enormous support with complex substance misuse clients at UCH
Newest team in SLAM

• Dr. Jonathan Beckett, Consultant on Triage Ward and Chair of the Consultants Group at the Lambeth Hospital says our team has “helped to promote a social and moral conscience in us all”

• Dr. Rob Harland Consultant Psychiatrist and Chair of the Consultants Group at the Maudsley Hospital says:

  “These people are very bright, they know the law. They can get to grips in 15 minutes with issues it takes us 2 hours to even start to work out. They’re brilliant.”
Hewett et al. A general practitioner and nurse led approach to improving hospital care for homeless people
BMJ 2012;345:e5999
KHP Pathway Outcomes – all homeless patients attending

• Context - Rough sleeping in London has increased by 90% between 2010/11 and 2014/15 after a steep decline in the 2000’s

• 9% reduction in A&E attendances, an 11% reduction in bed days in the measured cohort, 56% showed improved housing outcomes and the average length of stay reduced from 3.2 to 2.6 days
Bradford Pathway, patients seen by team full year stats

- 213 patients
- % Reduction:
  - A&E 35%
  - Admissions 38%
  - Bed days 54%
2 Centre RCT – Royal London & Brighton

- Quality of life scores (EQ5D-5L) improved post discharge for Pathway patients
- Proportion of people sleeping on the streets reduced from 14.6% in standard arm to 3.8% in Pathway arm
- The increased quality of life cost per QALY was £26,000
- JRCP accepted for publication Jan 2016
Pathway team development – a structured process

**STEP 1**
Discussions with Hospital Trusts
We open preliminary discussions with Hospital trusts, PCTs and regional authorities to consider possibilities...

**STEP 2**
Needs Assessment Commissioned
We are commissioned to work with Hospitals, regional and local care providers to quantify needs, consider resources and agree priorities... (We think any hospital with 200 or more homeless or 'tri-morbid' admissions per annum could benefit from the Pathway approach)

**STEP 3**
Team Recruitment & Training
Pathway teams are NHS staff. We work with the Hospital Trusts to recruit, train and support a local hospital-based Pathway team who will work with the most vulnerable and sometimes challenging patients...

**STEP 4**
Fully Operational Pathway Teams
We launch the fully operational team in the Hospital and provide ongoing monitoring and support...

**The process**
The process from opening initial discussions to developing a needs assessment, through to recruiting and training a team and eventually establishing a fully operational team in a hospital setting takes between one and two years. Maps on page 21 show the take-up of Pathway projects in London and UK regions.
### Evidence into practice

**Case Study: preventing homelessness and ill health through effective discharge**

<table>
<thead>
<tr>
<th></th>
<th>% discharged into suitable accommodation</th>
<th>% received health support on discharge</th>
<th>% received housing support on discharge</th>
<th>% readmitted into hospital within 30 days of a prior admission</th>
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</thead>
<tbody>
<tr>
<td><strong>All projects</strong></td>
<td>69%</td>
<td>58%</td>
<td>55%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Accommodation and link worker</strong></td>
<td>93%</td>
<td>68%</td>
<td>64%</td>
<td>22%</td>
</tr>
<tr>
<td><strong>Housing and nursing staff</strong></td>
<td>93%</td>
<td>89%</td>
<td>92%</td>
<td>23%</td>
</tr>
<tr>
<td><strong>Housing link worker</strong></td>
<td>68%</td>
<td>55%</td>
<td>62%</td>
<td>30%</td>
</tr>
</tbody>
</table>

52 projects funded through DH £10m

[www.homeless.org.uk/facts/our-research](http://www.homeless.org.uk/facts/our-research)

www.homeless.org.uk

Let’s end homelessness together
The Challenge

Adapted from the Intersectoral action for Health WHO 1986 diagram
What we are trying to achieve

Equitable access to high quality health and social care services
Empowering individuals and communities

Healthy places
Healthy homes
Healthy schools
Healthy food
Work and wellbeing
Reduce income inequalities

Adapted from the Intersectoral action for Health WHO 1986 diagram
FACULTY FOR HOMELESS AND INCLUSION HEALTH
Defining inclusion Health?

• Inclusion Health (IH) is a research, service and policy agenda that aims to prevent and redress health and social inequities among the most vulnerable and marginalised in a community.
Stronger together – Jan 2011

• Together we can command an irrefutable authority to address the health issues grounded in health inequalities and concerning which we all have expert knowledge

• The forward is to refine our standards..Also a commissioning blueprint...

• This can be our means of seizing the initiative in the gathering perfect storm of re-disorganisation.
Standards for commissioners and service providers

The Faculty for Homeless Health

Version 1.0
May 2011
2013 – DH funding from the National Inclusion Health Board supported the Faculty to develop a revised set of Standards to include Gypsies and Travellers, vulnerable migrants and sex workers
ED Audit-RCEM/RCP & Faculty

- Organisational recommendations and next steps
- To provide the best level of service EDs should ensure that systems are in place to identify and record homeless patients.
- All ED staff should be made aware of the homelessness information for staff, if available. If a pack is not currently available, consider developing one with relevant up-to-date information.
- Discuss explicitly including homeless people in your safeguarding policy for vulnerable adults.
- Consider linking multi-agency care plans to alerts for frequent attenders.
Recommendations and next steps

• ED's to continue to identify and care for homeless people, by making sure that particular problems such as mental illness and drug or alcohol dependency are properly addressed.
• Signpost homeless people for help and support in the community.
• RCEM and Faculty for Homeless and Inclusion Health to revise the draft Standards in the light of this pilot audit.
• RCEM and Faculty for Homeless and Inclusion Health to develop an on-line learning resource on the RCEM website to help ED improve their care of homeless patients
Faculty Activities

• Regular newsletter, meetings & annual conference
• RCEM Audit of quality of care in Emergency Departments for Homeless Patients
• RCP attitude to homeless patients survey
• Academy of Medical Royal Colleges Joint Statement on Inclusion Health
• Inter-professional post-graduate training in Inclusion Health
Faculty for Homeless and Inclusion Health

Training and Qualifications
What works for health care and multiple exclusion?

• Individual care coordination, supported by a multi-disciplinary team

• More than anything a trusting relationship with someone who cares
Join the Faculty at
www.pathway.org.uk/faculty/join/