Pathway and the Faculty for Homeless and Inclusion Health

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Pathway
Case 2

- Female, 55, multiple names / DOBs
- Stroke, alcoholism, incontinence
- Debate around mental capacity
- Failed engagement multiple agencies
- +++ hospital attendances over 12 years, at least 13 sites
- 5 year data in from 7 hospitals so far – 508 A&E attendances, 58 admissions
- 5 year cost ? £250,000
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

Story A. Slopes and cliffs in health inequalities: comparative morbidity of housed and homeless people. The Lancet, Volume 382, Page S93, 29 November 2013
Duration and frequency

- Transitional
- Episodic
- Chronic

Time

Housed

Homeless
Severity × Duration² = Health impact

Severity

- Temporarily staying with friends or family
- Staying in a hostel or bed and breakfast
- Squatting Emergency Hostels Rough sleeping

Duration

Health impact
Figure 1: Overlap of SMD disadvantage domains, England, 2010/11

Multiple health and social care needs

Physical health

Mental health

Drugs & alcohol

Social care needs

High costs - worst outcomes
The Pathway approach: ‘enhanced care co-ordination supported by a multi-disciplinary team’

- Multiple complex needs
- Tri-morbidity
- Severe and multiple disadvantage
- ‘Extreme’ medicine
- Inclusion health
- Multi/poly-morbidity
- Extreme health consequences of extreme inequality
What happens at the bottom of the gradient?

High

Social status

Health status

Low
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
• Care, connect, understand, advocate
Pathway team development – a structured process

STEP 1 Discussions with Hospital Trusts
We open preliminary discussions with Hospital trusts, PCT’s 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.
New additions to the Pathway network

- Medical respite – specialist step down provision: Bradford, Leeds, London...
- Extension to mental health – KHP
- Sustained community support – Brighton, Royal London
- Care Navigators – team members with lived experience – UCLH, Royal London
- ABI, PD? Psychologically informed services, trauma informed therapy, Data sharing, super MDTs? Street services?
- International
Pathway – what do we do?
What do teams do?

- Practical assistance
- Comprehensive health reviews
- Linking in with community services
- Help to find housing
- Reconnection work
- Frequent attender casework
- Safeguarding of vulnerable adults
- Analogous to a pain or palliative care team in hospital setting
• Maximising the benefit of admissions
• Expert and sensitive support team with specific skill sets
• Team fully linked in to homeless community services
• Delayed discharges
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 and substance misuse teams within the hospital and out into the community
Logic model example – SLAM Pathway team at KHP
inputs

- 0.2 integration lead
- 2x mental health practitioners
- 0.2 GP
- 0.5 housing worker

activities

- 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

outputs

- 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

outcomes

- 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

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
Our members range from a Westminster bicycle paramedic to professors of epidemiology and infectious diseases, from podiatrists to dentists, general practitioners, practice nurses, nurse consultants, district nurses, specialist nurses and psychiatric nurses, psychiatrists, psychologists, psychotherapists and counsellors, and many people with an experience of homelessness.

Our first task was to defend services from salami-slicing loss of quality by defining a set of quality standards. These standards were published in June 2011 at public event at St Martins in the Fields, Trafalgar Square and were accepted by Professor Steve Field on behalf of the Cross-Ministerial steering group on health inequalities.
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
What is 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.
Faculty Activities

• RCEM Audit of quality of care in Emergency Departments for Homeless Patients
• RCP Physicians attitude to homeless patients survey
• Academy of Medical Royal Colleges Joint Statement on Inclusion Health
• Inter-professional post-graduate training in Inclusion Health
Summary - what is the problem

• Long-term homelessness is a mark of complexity and multiple exclusion with roots in early childhood. Neglect and abuse lead to personality issues and mental illness, and attempts to self-medicate with alcohol and drugs leads to dependency and contact with criminal justice services. Lack of social support and personal resilience often culminates in destitution and homelessness. A deterioration in physical health follows, and the combination of physical ill health combined with mental ill health and drug or alcohol misuse (tri-morbidity) is often central to the challenge of managing homeless patients in an acute hospital setting.
What is the solution?

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

• More than anything a trusting relationship with someone who cares
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