

# Positive outcomes for homeless patients in UCLH Pathway programme

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## ABSTRACT

Pathway is the leading homeless healthcare charity in the UK. Established in 2009 after an audit of homeless patient admissions data, a model for holistic management was developed with the aim of improving both health and social outcomes for this vulnerable group. There are now 10 teams in hospitals across the country, where in-hospital GPs and nurses hold multidisciplinary meetings to address the housing, financial, social and health issues of patients. We conducted an audit of Pathway patients between November 2014 and November 2015 to determine if patients experienced any reduction in A&E presentation, admission or bed days following Pathway care, and explored the factors that may have contributed to this. Reductions between 38–78% were seen in these parameters, where long-distance repatriation, food and clothing donation and accommodation arrangements were likely to have played a role. This article describes some of the actions undertaken by the UCLH Pathway team to ensure comprehensive and individualised care was provided to a truly heterogeneous population, with insight from Medical Director Dr Nigel Hewett. Although funding for such models of care may be inconsistent nationwide, this article aims to provide ideas and inspiration for the management of this complex and disadvantaged population.

**Key Words:** Homelessness • Trimorbidity • Multiple-exclusion homelessness

In 2009, a GP-led 'Pathway' programme for care coordination of homeless people was first established at University College Hospital London (UCLH) (Hewett et al, 2012). Since then the approach has been adopted by a further nine Trusts and outcomes demonstrated by a randomised controlled trial (Hewett et al, 2016) and a narrative description of the approach at Kings Health Partners (KHP) (Dorney-Smith et al, 2016). This article examines new data from UCLH and describes how this approach has subsequently developed.

Homelessness is a term that can describe not only those that sleep rough, but those in temporary hostels, 'sofa surfers', and individuals living in overcrowded or unsuitable accommodation (Gill et al, 2013). Shockingly, these homeless men and women have an average age at death of just 47 and 43 years respectively, and during their lives will experience hospital admission 3.2 times more often than a non-homeless patient. Furthermore, these admissions last on average three times as long, driving up the unscheduled secondary care costs (Hewett et al, 2012).

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The two main concepts that led to the development of the Pathway programme are that of ‘multiple exclusion homelessness’ and ‘tri-morbidity’. The former is ‘a form of “deep” social exclusion involving not just homelessness but also substance misuse, institutional care and/or involvement in ‘street culture’ activities’ (Fitzpatrick et al, 2012. p.1). The latter is the presence of both physical and mental illness, and substance abuse – a phenomenon commonly experienced by homeless people (Hewett et al, 2012). Taken together, these concepts indicate that homeless people are a complex and extremely vulnerable population whose needs mean that the responsibilities of the medical profession extend far beyond managing isolated episodes of acute illness. A 2010 study of the unmet needs of a group of almost 1000 American homeless individuals supports this idea of a multimorbidity problem, identifying exactly what proportion of this group required, among other things, medical or surgical care (32%), mental health care (41%), and prescription medications (21%). In conclusion, the study called for a ‘more comprehensive model of health care for homeless individuals’ (Baggett et al, 2010. p.1331).

Since 2009, Pathway teams across the country have been applying their individualised and multidisciplinary form of care to homeless inpatients. The multidisciplinary care offered by Pathway is delivered through purpose-designed GP and specialist nurse-led ward rounds – an innovative way to bring the holistic skills and community networks of primary care onto the wards. The team also provide patient advocacy in relation to discharge and outpatient arrangements, and liaison with housing, legal and community medical representatives; the Pathway team have provided invaluable support in the effective and holistic care of homeless patients. Their dedicated Care Navigators, with their own experiences of homelessness, provide support and understanding, and follow-up if necessary to reduce the likelihood of readmission.

Outcomes of these interventions were analysed at UCLH, the Royal London (RLH)

and Royal Sussex County hospitals (RSCH) – the latter two as part of a randomised two-centre controlled trial. Research at UCLH found that discharged patients who had received Pathway care experienced a 30% reduction in annual bed days from 2008–2011 (Hewett et al, 2012). At RLH and RSCH, patients judged themselves to have improved management of money and relationships both on discharge and follow up, and the hospitals saw a reduction in rough sleepers on discharge from 14.6 to 3.8%. This led to an increased quality of life cost per quality-adjusted life year of £26 000 (Hewett et al, 2016). It is clear that Pathway’s aim for a multi-faceted approach to improved wellbeing can be effective.

Limitations in these previous studies are acknowledged, however. Self-assessed coping with drugs and alcohol did not improve after receiving Pathway care at RLH and RSCH in 2013. Furthermore, the reduction in A&E attendances after Pathway care was not statistically significant (Hewett et al, 2016). This audit attempts to understand if the picture has changed in the four years since then.

## Methods

To explore this, an audit was conducted at UCLH in 2016, to look at the rates of A&E attendance, hospital admission and bed days in the 90 days before and after Pathway care for 400 homeless patients between 2014–2015.

Following this, the records of a 10% subset of audited patients were further studied to gain further information regarding the care they received. For this, patient discharge summaries, Emergency Department (ED) clerkings, physiotherapy and Occupational Therapy (OT) notes and the Pathway team’s own records of patient assessments and multidisciplinary team minutes were consulted.

The audit was conducted by two medical students on secondment from University. An online screening tool from the NHS HRA National Research Ethics Service deemed ethical approval not to be necessary. Access was granted and training provided to allow a search of patient admission data in the forms listed above.

## Results

The results of this audit can be seen in *Table 1*, which demonstrates substantial decreases in all three parameters. Given that secondary care for the homeless is estimated to cost eight times more than that provided for non-homeless patients, these decreases could lead to dramatic savings. Furthermore, previous cost-effectiveness analyses of the Pathway programme predicted a 'conservative estimate of £200 a day' in terms of net hospital savings at UCLH (Hewett et al, 2012). Reduced numbers of patients requiring admission and reduced costs of caring for those who do suggests a strong link between the provision of Pathway's many interventions and improved outcomes for both patients and hospitals.

## Discussion

It is not possible to prove that the positive outcomes highlighted by the recent audit are a direct result of Pathway and Pathway alone. It is not unreasonable to assume that the provision of warmth, a bed, regular balanced meals and contact with a team of health professionals and social workers would improve outcomes for any homeless patient. However, these explanations for improved patient outcomes are transitory and so are likely to be attributable for the short period of time following discharge at best. For this reason, further study of a randomly-selected 10% subset of audited Pathway patients was undertaken. Understanding of their patient experience in terms of presentation, admission and inpatient care, discharge and follow up, with particular reference to the specific ways in which Pathway helped them, provides

more detail of Pathway's role in their improved outlook.

## Presentation

Presenting complaints of the cohort were predictably varied, although alcohol was the cause in exactly one third of cases, resulting in encephalopathy, seizures and trauma. Twenty-five per cent of patients received support from the Drug and Alcohol liaison team. More non-specific ailments such as abdominal pain and shortness of breath made up 10% of admissions, although more specific cases of cellulitis, groin abscess and a 'mental health crisis' were also cited. One patient was admitted for IV antibiotics after presenting with bilateral excruciating ear pain due to infection, having scrunched up pieces of newspaper and put them in his ears to try and keep them warm while sleeping on the streets. The heterogeneity of this proportionally small number of admissions gives a clear idea of the breadth of medical specialities required to address this population.

## Admission and inpatient care

Ten per cent of patients absconded before they had a chance to receive any treatment, despite being made known to the Pathway team. Of those that did stay, the mean length of admission was 6.3 days.

In this time, Pathway provided a variety of interventions. Alongside the relevant medical care, physiotherapy and dietetics provided to the cohort, their additional referral to the Pathway team allowed them to receive additional care. Twenty-five per cent of patients were provided with clean

**Table 1. Hospital attendance and admission rates in the 90 days before and after 'Pathway admission' spells in UCLH homeless patients (n=396)**

|                             | 90 days prior to pathway admission | 90 days post pathway admission | Percentage change |
|-----------------------------|------------------------------------|--------------------------------|-------------------|
| <b>A&amp;E presentation</b> | 747                                | 466                            | 37.6%             |
| <b>Hospital admission</b>   | 1081                               | 318                            | 66.0%             |
| <b>Bed days</b>             | 2507                               | 549                            | 78.1%             |

*‘Continuity of care in this often nomadic population can be a near-impossible task. Yet, patients with such chronic and multidisciplinary problems invariably require regular follow up’*

clothes and shoes, and help with detailed local council housing application forms. The team also assisted patients with GP registration and homeless declarations, and liaised with Embassies, legal advisors and drug and alcohol teams. Pathway ensured that the small luxuries available to other patients were not denied to theirs, providing TV and calling credit to many of the patients. Such gestures were likely not only to help dispel feelings of being ‘treated differently’ to other patients (Hewett et al, 2012), but also help encourage patients to stay until their treatment and ongoing care plans could be completed.

### Discharge

Fifty-eight per cent of patients were given housing and shelter advice or repatriation assistance. For those patients originating from elsewhere in the country, housing support officers were contacted and introductions made. Upon leaving hospital, taxis were arranged and paid for 10% of patients. Train and coach tickets were also purchased, and for those more local, pre-paid Oyster cards were given. During the time frame studied, Pathway arranged and funded 22 nights of cheap accommodation for patients in order to ease the transition back into the community.

The Pathway team consulted with various charities designed to help people who wished to get back to their homes and families abroad, as well as assisting the hospital Integrated Discharge Team in more challenging cases. In one instance, a Eurostar ticket was bought to help home a patient who wanted to get back to France – where accommodation too had been organised. On another occasion, a Lithuanian patient was able to return home after

suffering a stroke which left him hemiplegic. The patient required a stretcher and three seats on an aeroplane in order to travel safely and comfortably, with an additional seat for accompaniment. Although a costly solution, this arrangement amounted to less than the cost of ongoing care of the patient in a UK hospital, and facilitated recuperation with family support.

### Follow up

Continuity of care in this often nomadic population can be a near-impossible task. Yet, patients with such chronic and multidisciplinary problems invariably require regular follow up. Pathway’s routine provision of assistance with GP registration and communication with hostels to ensure retention of patient’s beds help address this issue.

In association with the UCLH@Home service in the hospital, Pathway has successfully run a pilot using two beds in a local hostel to allow homeless patients to leave hospital for respite rather than being discharged onto the street. The hospital pharmacy innovated with daily dispensing prescriptions to a local community pharmacy, to allow this facility to be available for patients on methadone. The pilot has demonstrated a need for a larger facility for homeless patients across London.

### Conclusion

It seems that the assertions made about Pathway by its users back in 2012 remain true. Comments about being given the opportunity to talk without judgement, remaining in hospital for the necessary treatment on the basis of trust, and being reunited with family after years (Hewett et al, 2012) all continue

## KEY POINTS

- Complex multidisciplinary care has shown to improve their health and other self-assessed outcomes
- Pathway teams of in-hospital GPs and nurses, amongst other team members, have developed a model of holistic care for homeless patient
- UCLH saw significant reductions in presentation, admission and bed days of patients previously treated with the Pathway model of multidisciplinary care
- Support across the areas of not just health but housing, finance and social support is needed

to ring true at UCLH thanks to Pathway's commitment to holistic care.

There are currently 10 Pathway teams supporting NHS Trusts in the UK – half of these are based in London, and the remaining five in Bristol, Manchester, Bradford, Leeds and Brighton. The teams work closely with a number of other national charities and organisations, including Shelter, NHS England and the CQC. More locally, Pathway teams collaborate with charities such as TB Find & Treat and Justlife to ensure ongoing care after discharge. As Medical Director Dr Nigel Hewett sees it, 'there is a growing evidence base behind the Pathway approach to care coordination for homeless people. This has protected services through a period of cuts and is supporting our ambition to roll out Pathway teams for every UK hospital caring for significant numbers of homeless people.'

For now, limited resources mean provisions should perhaps be aimed initially at the areas of greatest need. For several years it has been understood that outcomes of substance use are clustered geographically (Karriker-Jaffe, 2011) and, accordingly, the RCGP created in 2013 a commissioning framework for social inclusion that recommended service provision proportional to needs in certain geographic areas (Gill et al, 2013).

While availability of resources for homeless health nationwide may be limited, unfortunately the problems of homelessness and social exclusion are not. Whether or not there are opportunities to initiate or develop facilities such as Pathway in your

area, hopefully there are ideas to take away from this evaluation of their services in the hope that specialised, multidisciplinary care for the homeless might become the standard throughout the country. [BJHCM](#)

■ For further information, please visit [www.pathway.org.uk](http://www.pathway.org.uk).

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