Integrating health care for homeless people: Experiences of the KHP Pathway Homeless Team

Samantha Dorney-Smith, Nigel Hewett, Zana Khan, Rachel Smith

ABSTRACT

This article describes the setting up of a multidisciplinary, multi-agency homeless team within the King's Health Partners hospitals in South London. The KHP Pathway Homeless team has been operating since January 2014, and works across three NHS Trusts, and five hospitals. The team is affiliated to, and forms part of a Pathway network of nine teams in acute care settings nationally. This article outlines how the team has integrated primary and secondary care (the team is GP-led and works alongside the community homeless teams); the voluntary sector with the NHS (the team has four third sector organisations providing staff within a 20-person team); mental health and physical health (one of the trusts is a mental health trust and the team has both physical and mental health care practitioners); and health and housing (the team assists patients into housing, and has built relationships to assist with this). As part of the operational detail, the highly successful homeless frequent attenders forum, which involved a large number of community partners, is discussed. Information governance and practical challenges are outlined. In the first year of operation the team received 1603 referrals, and housed or reconnected 56% of those that were admitted. Case studies of improved outcomes are profiled and outcomes benchmarked against other Pathway teams.

Key Words: Homeless health • Frequent attenders • Integration • EMIS Web

The annual cost of unscheduled care for homeless patients is eight times that of the housed population (Department of Health, 2010) and homeless patients are overrepresented among frequent attenders in accident and emergency departments (A&E). Despite this expenditure, the average age of death for homeless patients is just 47 years (Thomas, 2012) and patients have a reduced quality of life caused by multi-morbidity. Hospital stays should present an ideal opportunity to engage homeless people and link them into community services, but historically this has not been true. Tri-morbidity (the combination of physical health, mental health and addiction problems) is often central to the challenge of managing homeless patients in a hospital setting (Hewett et al, 2012).

The Pathway charity has developed a model of enhanced care co-ordination for homeless people in hospital that is now being adopted

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in many hospitals nationally. The King's Health Partners (KHP) Pathway Homeless Team service commenced work in Guys and St Thomas' (GSTT) and King's hospitals in January 2014, following a needs assessment (Hewett and Dorney-Smith, 2013). The needs assessment established the number and cost of A&E attendances and admissions (including re-attendance and readmission data) arising from homeless clients attending the three trusts and engaged a range of stakeholders.

Lambeth and Southwark clinical commissioning groups (CCGs) funded an initial pilot, but have recently confirmed ongoing funding. In February 2015, the team extended into Lambeth and Maudsley mental health hospitals, with generous funding from the GSTT and South London and Maudsley (SLaM) charities. As such, the team works over a large geographical area that covers the five London boroughs of Lambeth, Southwark, Lewisham, Westminster, and Croydon. This area had an estimated 16 491 homeless people in 2014–15. This figure represents rough sleepers, clients living in homeless hostels, clients living in second-stage-supported accommodation, and Part VII statutory homeless declarations at the local authority.

Table 1. What does the KHP Pathway Homeless Team do?

- Undertakes holistic health, housing, and social care assessments
- Provides complex care coordination where this is required
- Provides specialist advice to inpatient teams (e.g. regarding addictions, mental health, mental capacity, cognitive deficits, and the management of tri-morbidity generally)
- Works across primary and secondary care and statutory and voluntary sector boundaries to ensure health and social care needs are met in the community
- Assists A&Es and inpatient teams to reduce the high rates of self-discharge, and re-attendance in this client group
- Befriends patients to ensure engagement, and reduce self-discharges
- Provides advice about to patients and staff about housing law, and provides assistance to find housing
- Provides skilled advocacy at homeless persons units where this is needed
- Safely reconnects people to their area of origin when this is relevant and appropriate
- Upskills secondary care staff by providing training/resources
- Lobbies for political change when this is required

Service attributes

Overview

The KHP Pathway Homeless Team works both on wards and within the emergency department (ED) to provide advocacy, support and quality discharge interventions for homeless clients attending any of the KHP hospitals. The team works in close collaboration with hospital discharge teams. The dual aims of the team are to improve the quality of care for homeless patients, while reducing potentially delayed or premature discharges. There is an overarching aim to reduce unscheduled admissions and ED attendances. The team is affiliated to, and forms part of a network of nine Pathway 'Homeless Ward Rounds' based in acute care settings nationally. Clinical practice within the teams is guided by Pathway principles of practice. *Table 1* outlines the most common interventions delivered by the team.

The KHP Pathway Homeless has three satellite teams based within the three trusts: GSTT, King's and SLaM. The current staff team consists of 2 part time GPs, a social worker, an occupational therapist (OT), 2 general nurses, 2 mental health practitioners (who are currently both mental health occupational therapists), a business manager, 4.5 housing workers, 0.6 peer advocate and a network of volunteers.

The housing worker and peer advocate element of the team is provided by the voluntary sector, currently via service level agreements with 4 separate organisations with links to the local boroughs (St Mungos, St Giles Trust, the Passage, and Groundswell). This allows the team to benefit from a wide range of pre-existing voluntary sector relationships. These workers all have honorary contracts for the trusts in which they work. Each satellite team has a once-weekly case review meeting. There is also both a full team meeting, and an external reflective practice session with a clinical psychologist once a month.

Operational management of the staff is delivered by clinical managers within these trusts, but there is an additional 0.6 Band 8a integration lead post that binds the team, and

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leads and develops all elements of the team's integration with community services. This post is based in the community, within the Health Inclusion Team (HIT).

The HIT is a nurse-led service that works across Lambeth, Southwark and Lewisham delivering outreach primary care in day centres and hostels for homeless people asylum seekers and vulnerable migrants, and in addictions settings. Line management for the integration post, and strategic guidance for the Pathway team also comes from community services. The team aims for a fully integrated approach to care with local specialist GP practices, and physical and mental health community homeless teams. The team also works in partnership with a wide variety of other partners including mainstream GPs, housing departments, social services, voluntary sector outreach teams and hostel managers, and the London Ambulance service.

Specialist team roles

The satellite teams are either nurse or mental health practitioner-led. The lead practitioners have an overview of the case load, and allocate work each day. There is also a social worker who provides specialist expertise regarding clients with no recourse to public funds, ordinary residence disputes, mental capacity and safeguarding issues. Post holders have experience of working in homeless healthcare or other relevant settings (e.g. A&E). Some other roles on the team are less usual, and these are discussed below. The team has a holistic case management approach, where the most appropriate member of the team takes the lead for individual patients, and the team frequently calls case conferences to achieve the best outcomes.

GP

Clinical leadership is provided by GPs. GPs bring generalist skills into a specialist environment, and enable siloed care to be challenged. The GPs have considerable expertise in addictions, mental health, and managing complex multi-morbidity within a homelessness context, and advise admitting consultants and their teams of the best course of action clinically. They also provide primary care in-reach—ensuring for example, that chronic disease checks are undertaken opportunistically for more chaotic clients. A 'primary care sticker' has been introduced—essentially an aide memoir to hospital doctors to consider using the inpatient admission to undertake primary care work. As part of this workstream GPs undertake clinical audit on behalf of the whole hospital. One recent audit demonstrated that only 50% of the homeless cohort were receiving HIV screening during their admission. Finally, GPs write expert letters to housing that encompass all the key information that is required for an independent medical assessor to decide whether someone is in 'priority need'.

Occupational therapy

Occupational therapy has proved an invaluable role for this team, with both physical and mental health OTs having been employed. OTs have expertise in assessing cognitive deficits and disability, and supporting and promoting meaningful activity. They also have a key role in evidencing support needs to housing and social care. As such, the role has become central to the work of the team. The team OTs are now developing a professional clinical network of OT's working in homelessness to help support each other and consolidate the role.

Housing worker role

The team's housing workers provide in-depth knowledge of housing law, and have specialist advocacy skills. As part of their remit they identify client local connections, liaise with local authorities, and prepare housing applications in advance. They often escort patients to housing options to directly advocate for them, and use their local relationships to negotiate the best housing solutions. Housing workers also do a lot of reconnection work. Clients can be reconnected locally (to another borough), nationally or internationally. This may be as simple as providing a ticket home, but can also include comprehensive packages where clients are escorted back to specific planned provision—either by the team or other agencies. The housing workers are seconded, but still have support from their own organisations within the terms

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Figure 2. Case studies

Role of the GP and housing worker

Patient 1: 38-year-old male, rough sleeping at first contact. 20 A&E attendances and 13 admissions April 2013–March 2015, 94 bed days.

Medical problems: Past IV drug use, alcoholism, HIV, bowel resection, stoma, leg ulcers, clots (DVTS), endocarditis. Personality disorder, previous psychosis, suicide attempts.

Other problems: Multiple past evictions, DNAs for OPAs, poor engagement, frequent moves around London making local connection unclear.

Activities initiated by Pathway team: Team slowly built a relationship, making him a priority when he was in hospital. Interventions such as providing TV access at his bedside (which normally needs to be paid for, and therefore would have been unavailable to him), obtaining small sundries, and phoning him regarding follow-up appointments gradually helped to build trust. Gradually the team had a full understanding of his medical and social history and context, and all his community and follow-up needs. At one point he was supported into a suitable hostel and abandoned this (for essentially legitimate reasons), but this was frustrating for everyone. However keeping 'in relationship' despite set-backs is an important role for the team.

GP role has been to gain a thorough understanding of all his medical and psychiatric needs, in order to advise acute physicians and community providers and ensure that these needs are met. An authoritative and holistic summary has helped his housing case.

Housing worker role has been to advocate (across borough boundaries) for a person who has proved challenging to manage in a residential setting, and convince the client themselves that being in a hostel offers a better future.

Overall achievement: Has now been stable in a hostel for 10 months, and has only had 3 attendances and 1 admissions during this time.

of the service level agreements. Once a month, expert supervision is provided from one of the senior members of each organisation, which enables these staff to keep up-to-date.

Peer advocate role and volunteers

The voluntary sector agency Groundswell provides a Peer Advocacy service to the KHP Pathway team. The paid project worker works in hospital with patients identified at team case review meetings. The worker engages these clients in hospital, and is then able to escort them to follow-up health appointments after discharge, either personally or with support of a team of around 25 peer volunteers. Referrals are also accepted from the HIT for hostel clients who have recently been discharged from KHP hospitals, and are identified to be at risk of re-attendance or re-admission.

All peer advocates have personal experience of homelessness, enabling them to successfully engage with 'hard to reach' clients. Volunteers are supported through a Volunteer Progression Programme with the aim of progressing to paid peer advocates, or other paid work. The programme includes a comprehensive training programme, group supervision, and a person-centred coaching programme. Using the 'Supported Permitted Work' scheme, Groundswell are able to support volunteers

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Figure 2 (continued). Case studies

Role of the occupational therapist

Patient 2: 44-year-old male, alcohol dependent, homeless hostel client. 33 attendances to A&E in 2014, nearly all via ambulance. Self-discharged when admitted.

Medical problems: Anxiety, depression. Long term gastritis, abdominal pain, peri-rectal bleeding. Probable learning difficulties and personality issues (undiagnosed).

Other problems: Poor engagement with GP and general lack of trust in health care professionals. Multiple DNAs for arranged procedures and investigations. Poor medication compliance.

Activities initiated by Pathway team: Visited at hostel to understand problem. Community mental health team assessment arranged—but patient was not taken on by them. Liaison with HIT to enable extra support. Was re-engaged with his brother. OT assessment then revealed significant attachment difficulties, uncertainty about the future, boredom, a problematic relationship with food, integration of the 'sick role' into his identity, and an externalised locus of control.

OT interventions: Engagement with addiction services and peer advocacy (previously refused). Case conference arranged and attended. Assisted to link in with Recovery College (first visit escorted), and work done together around building an adaptive daily structure and timetable. Health education and promotion around alcohol, diet, medications and use of NHS services. Investigations eventually undertaken with support—nil sinister found.

Overall achievement: 1 attendance since OT intervention

currently receiving Employment Support Allowance to become peer advocates, thus aiding progress back into work.

Many other Pathway teams benefit from a similar role called a care navigator. In this role, ex-homeless people ('experts by experience') are trained up to undertake advocacy and formal housing work within the hospital teams.

EMIS Web

To support integration the team uses EMIS Web as its clinical database. EMIS is a clinical information management system commonly used by GP practices which has evolved to enable information sharing. EMIS Web was the existing clinical system of the HIT, and has now been installed across the three trusts for the Pathway team. This was a challenging process, not least because of the need to work with four IT teams. Firewall issues were time consuming. Information governance details needed to be worked out carefully because of voluntary sector involvement. However the HIT and KHP Pathway Homeless Team use the same EMIS instance, so once installed, integration was immediately enabled. EMIS Web is the database used by many other homeless healthcare providers across London, which is an additional major benefit. The team is now developing data sharing agreements with two other Pathway teams, four specialist GP practices, and several other interested locally enhanced service GP practices.

Relationships with housing

The pressure on housing options departments is widely recognised, with many London local authorities having over 20 000 people waiting on their housing lists. However, set within this context, a recent report by Dobie et al (2014) emphasised the challenges that homeless people face when approaching housing options

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departments without support. As such, the development of good working relationships with local homeless person's units has been fundamental to our ability to ensure safe and sustainable arrangements after discharge.

Initially there were some relationship difficulties, as housing departments were concerned the team would present clients who were not homeless, eligible, or in priority need, and those without a local connection. However by offering on-site assessments with highly knowledgeable and experienced housing workers, the homeless team have been able to identify an appropriate cohort who do require local statutory assistance. Consequently a number of clients who are likely to be ineligible for statutory housing interventions are effectively diverted to the voluntary sector or other appropriate options. Where statutory interventions are required a joint approach to decision-making with local housing departments has been developed, which aims to ensure that people are directed to the correct housing pathway immediately. Relationship-building has been key. A hospital protocol was developed by Southwark, which has since been adopted by other boroughs, and a number of managers have reviewed and refined the protocol. The following feedback was received from a senior housing manager in Lambeth after progress through joint working, 'There has been significant improvement on hospital discharge… I appreciate your support, thank you very much.'

Frequent attender forum

The clients discussed in the frequent attender forum are some of the most complex and challenging that the team sees—both clinically, and for the organisations they attend. These clients have high levels of unmet need, despite their frequent attendance. The forum was initiated by an A&E nurse, who later became one of the KHP Pathway Homeless team staff members.

The project started when data was obtained for the initial needs assessment for the Pathway team, but was augmented by further detailed data analysis on the demographics, patterns, and causes of frequent attendance in this group. 70% of did not attend (DNA) rates were noted in follow-up outpatient appointments had been made, and low GP registration rates in those who DNA. Currently frequent attender work largely focuses on patients from Lambeth, Southwark and Westminster.

Regular meetings provide a focus for the work, and involve statutory, charitable and voluntary organisations from Lambeth, Southwark and Westminster including psychiatric liaison and substance misuse workers from the acute hospitals; the HIT; the Westminster Homeless Health Team (Westminster outreach primary care team); the START and Joint Homelessness Team (the local homeless community mental health teams); hostel managers; street outreach teams; specialist GP nurses/practice managers; day centre representatives; housing commissioners; and the London Ambulance Service.

Driven by the desire to improve health outcomes and social outcomes for this group, engagement has been high and the network of contacts continues to grow. Searches identify rough sleepers and homeless hostel-dwelling clients attending A&E over 5 times in 3 months, and lists are circulated prior to the meetings, to allow services time to research the clients. An information sharing protocol, and the innovative creation of GSTT sponsored NHS.net accounts for charitable and voluntary sector staff, enabled the wider multi-agency approach—although other secure electronic information sharing solutions are now being considered. No Fixed Abode and hostel clients are discussed in separate meetings to maximise the benefit and relevance to specific stakeholders.

Care plans and alerts are produced on as many clients as possible. These documents are made rapidly accessible to A&E frontline staff, reducing the A&E department's need for information gathering, and assisting with complex decision-making. The team also reaches out to communicate with other Pathway teams, and relevant health services where clients are transient and attending services outside our hospital catchment areas. This forum has now been replicated in other hospitals.

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Outcomes

Annual reports for the service can be downloaded from the Pathway website. (www.pathway.org.uk). During the first year of the service, the team received 1603 referrals (GSTT 1086; King's 517) for 1414 individuals. 60% of clients at GSTT, and 45% of clients at King's reported being rough sleepers. Unsurprisingly 68.5% of those identified as homeless frequent attenders were alcohol dependent; 24% of clients had no GP on referral; and 89% referrals were seen or had case work done by the team during the pilot period.

EMIS Web data analysis for Pathway patients across KHP between April and August 2015 who had comprehensive health assessments completed confirmed tri-morbidity. 78.4% of patients had a physical health problem, 49.9% had a mental health problem, and 60.3% had a substance misuse problem. Blood-borne virus (BBV) prevalence was high, with HIV at 5%, hepatitis C at 8.8%; and 1.7% had a history of tuberculosis. (148)

Housing

During the first year, 56% of admitted clients referred to the GSTT and King's services, had an improved housing status on discharge. As part of this 100 people were successfully presented at homeless persons units, 51 people were reconnected outside London and internationally, (including to Australia, and the Philippines), and 65 people were reconnected to other London boroughs. Most of those reconnected also gained accommodation. Overall the team claimed a positive life change for 336 people, a considerable achievement given the challenges of the client group. Where housing situations were not resolved, clients received advice and signposting, while many cases remained ongoing. 2015 data is still being analysed for GSTT and King's, however we do know that the housing outcomes in SLaM have been even better. In the first year, 69% of clients referred to the SLaM team have had an improved housing outcome.

Client experience

Client feedback has been gained through client feedback forms, focus groups, and structured interviews with client volunteers. 'You did more for me in 48 hours than anyone else did for me in 17 years' was a comment on one feedback form. The team deliberately developed a simple analogue 1–5 scoring scale (where 1 is poor and 5 is excellent) for clients to score their satisfaction with the service at the end of the feedback form. The process at each hospital is different, but at GSTT feedback forms are undertaken by hospital volunteers. In 2015, a total of 57 forms were received back (6% of the referral population), with the average score being 4.4.

Feedback has helped shaped service direction, and understand areas that need development. We learned that clients often feel uncomfortable telling their stories at their hospital bed even when the curtain is drawn round, and that there is a need to maximise community support on discharge as clients can feel abandoned after a period of intensive support in the hospital.

Hospital culture change

At times the team observes situations that will be familiar in our current climate – premature discharges, low thresholds being employed for bad behaviour (with no management techniques being tried or employed), and inexperienced staff effecting the overall quality of discharges. The high pressure environment often means that vulnerabilities and clinical risks go unidentified in homeless clients. In addition, many opportunities to deliver essential clinical interventions are missed due to siloed care.

The team provides advocacy for individuals and support for staff as well as a monitor on a system level. The team attends a wide variety of meetings including clinical effectiveness committees, emergency care planning meetings and local ward based meetings to raise concerns, and offer advice and solutions; and provides training to all disciplines.

Early indications are that cultures are changing—across the three trusts there is increased awareness of the needs of the client group, and the executive teams have embraced the teams fully. Where disagreements have occurred in the process of resolving cases, there is always a consensus in the end that outcomes have been better as a result of increased debate.

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One lead consultant recently said that the team 'are helping to give us a moral conscience…we don't try to discharge people homeless any more'.

Secondary care usage data

Analysis of secondary care usage has been difficult. As 'homelessness' is not routinely recorded on hospital databases, at GSTT we used NFA (no fixed abode), known local hostel addresses, or registration with local specialist homeless GP practices, to identify a group of homeless patients for comparative data analysis. The King's team extracts data on clients with the ICD-10 'Homeless' code on the notes, and the SLaM team searches for free text instances of the words 'homeless' 'NFA' and 'no fixed abode'. All methods have some benefits and drawbacks. For example, the GSTT method does not pick up sofa surfers and patients being evicted, but the King's method relies on patients being coded as homeless.

Using the method above, there was a 9% reduction in A&E attendances (4322 to 3936), and an 11% reduction in bed days at GSTT between 2013 and 2014. Admissions increased 9% however (1058 to 1158), probably reflecting the fact that hospital staff are now more responsive to the needs of this client group, and that clients are more willing to be admitted. Lengths of stay reduced. At King's there was a 12% reduction in A&E attendance (773 to 677), but a 15% rise in admissions (103 to 118). The team had many successes with frequent attenders across both sites in 2014. For example, an analysis of 8 top frequent attending clients that were targeted during the first 6 months of the forum (Dec 2013–May 2014), showed an average combined cost for these clients of £115 274 per year between 2011 and 2013. In 2014, this dropped to £11 576 (See *Figure 3*).

Cost savings

The team is able to make cost savings for the commissioning CCG by reallocating the charging of clients who are registered on the hospital system as having no fixed abode or GP. In these cases, charging defaults to the borough of the hospital at which the patient attends. Often patients do have a GP, but just don't remember this in A&E. The team routinely checks the NHS Spine to see if clients are registered, and changes hospital system details appropriately. Not only is there a financial benefit to this intervention, it also ensures discharge information is being received.

Benchmarking outcomes against other Pathway teams

In terms of housing outcomes, a Homeless Link report (2012) showed that in 2012, more than 70% of homeless patients were being discharged from hospital back to the street without their housing or health problems being addressed.

Benchmarking secondary case usage outcomes is somewhat more difficult, as the KHP team outcomes are based on system wide analysis of all homeless patients presenting at the hospital—not just those seen by the team. Most other teams have used an audit approach based on outcomes for patients treated. However, once this is taken into account, the results seem favourable and in line with the other teams. The Bradford Pathway team, part of Bevan Healthcare, analysed secondary care usage for 90 days after discharge for the patients seen, and showed a 35% reduction in A&E attendances, 38% reduction in admissions and 54% reduction in bed days (Bevan Healthcare, internal audit, personal communication). The MPath service in Manchester, provided by the Urban Village Practice concentrated on 100 homeless frequent attenders and showed a 47% reduction in A&E attendances, 48% reduction in admissions and 39% reduction in bed days (MPath 6-month pilot review report December 2013).

The first Pathway team at University College London Hospitals did use a similar data approach to the KHP Pathway team and demonstrated a 30% reduction in bed days following introduction of the service (Hewett et al, 2012), however, this has reduced over time. This effect was also seen in the KHP Pathway team, and is discussed later.

The strongest evidence for cost-effectiveness of the Pathway intervention is provided by a two-centre randomised controlled trial carried out at the Royal London and Brighton and Sussex

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Figure 3. Frequent attender successes

		2011		2012		2013		2014		History and intervention
		A&E	Adms	A&E	Adms	A&E	Adms	A&E	Adms	
F, 56	STH	50	11	26	6	33	3	1	0	Alcoholism and stroke. NFA with no GP. Pan-London frequent attender visiting at least 13 hospitals. 508 A&E attendances and 58 admissions known over 5 years. Multiple names and dates of birth. Liasion with multiple other partners and Brent Social Services. Assisted into Nursing home placement in early 2014.
	King's	15	4	13	2	11	1	2	0	
M, 41	STH	59	9	58	8	62	4	19	4	Alcoholism, mental health, head injuries. Hostel client with GP. Pan-London attender. Several multi-agency case conferences called. Assisted to engage with psychologist. Behavioural management plan in A&E and special case status at GP initiated. Prioritised for extra support from all services. Spent later half of 2014 dry.
	King's	128	1	3	0	12	1	6	0	
M, 35	STH	41	6	58	8	27	6	1	0	Alcoholism, fits, cardiac problems. Pan London frequent attender. EEA National with no recourse to public funds, as not excercising treaty rights. Assaults on A&E and LAS staff, and other staff. Liasion with community safety, UKBA. Placed in detention in early 2014.
	King's	4	2	14	1	3	0	0	0	
M, 41	STH	18	13	14	8	15	5	0	0	Alcoholism, liver problems. Sofa surfer with no GP. Pan London frequent attender. Three names and DOBs. Overstayer with no recourse to public funds. Assertively outreached and supported by HIT team. Assisted to go home to own country in Mar 2014.
	King's	17	2	28	2	36	5	0	0	
M, 31	STH	NK	NK	42	11	10	4	0	0	Alcoholism, fits. EEA National with no recourse to public funds. Assisted into christian detox in north of UK in late 2013, escorted by outreach team. First success of the frequent attender forum when it was intiated. Has not returned.
	King's	NK	NK	29	5	0	0	0	0	
M, 67	STH	4	3	2	1	27	10	1	1	Alcoholism, mental health. NFA, previously lived independently, deterioration not picked up. Liasion with GP and Lambeth hospital promoted better engagement and service usage. Moved into hostel with support of outreach team.
	King's	NK	NK	NK	NK	NK	NK	NK	NK	
M, 68	STH	0	0	2	0	9	3	0	0	Alcoholism, fits, falls. Hostel client with GP. Too high support needs for existing hostel. Assisted into nursing home placement in Feb 2014.
	King's	NK	NK	NK	NK	NK	NK	NK	NK	
M, 58	STH	NK	NK	NK	NK	12	4	1	0	Alcoholism, fits, falls. Hostel client with GP. Too high support needs for existing hostel. Case put together for move to specialist residential care placement in partnership with social services.
	King's	1	0	21	3	4	1	1	0	
Total		337	51	310	55	261	47	32	5	Cost over 2011–2013 = £119 326 + £122 380 + £104 118 = £345 824 Cost in 2014 = £11 576
COST (£)		39766	79560	36580	85800	30798	73320	3776	7800	
COST (£)			119326		122380		104118		11576	

University Hospital. This did not show statistically different durations of stay, but did show the proportion of rough sleepers on discharge reduced from 14.6% to 3.8% with Pathway support, and the patients had improved quality of life scores on discharge and follow-up. The increased quality of life cost per quality-adjusted life year was £26 000.

Discussion

It is now widely accepted as good practice to

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make some form of specialist provision for the discharge of homeless people, and comparison of different approaches to discharge planning found that those with a dedicated clinical component (like Pathway) had the best outcomes (Albanese et al, 2016). It is important to recognise that this is a 'long game' for many homeless clients.

Although there may be considerable immediate benefits when a hospital discharge is set up—the KHP team saw a bed day reduction of 24% in the pilot phase—this is probably due to the immediate resolution of some less challenging cases. Ultimately, many of the client group are entrenched and chaotic, with multiple complex needs and will need a period of relationship-building and trust to bring about changes. Also, many of the remaining cases will hard to place for example, 'young olds', elderly clients needing care placement, or clients with no recourse to public funds (including EEA nationals).

It is important to note that as relationships develop with the more challenging clients, there may be an increased preparedness to seek help at hospital. As such, secondary care usage costs may not drop dramatically. Longer term benefits may also be seen in the wider health care economy for transient clients (e.g. across a number of trusts), or indeed to the wider state economy (by reducing criminal justice, and eviction costs), rather than accruing at the local trust. It is also important to note the current context of spiralling demand—rough sleeping doubled nationally between 2010 and 2015 (Department of Communities and Local Government, 2015).

The Marmot (2010) review states that 'To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism'.

In line with this, the vision of Public Health England expressed through the Outcomes Framework, is 'to improve the health of the poorest fastest', and the *Health and Social Care Act 2012* imposed, for the first time, a statutory duty on all health care providers to 'have regard to the need to reduce health inequalities' by means of the services which they provide. Ultimately, improved care for homeless people might best be viewed as an example of Michael Porter's value-based health care: 'outcomes that matter to patients, expressed in terms of the cost of the whole care cycle' (Porter, 2010). BJHCM

If you would like further discussion about developing a Pathway team in your hospital please contact Pathway Medical Director Dr Nigel Hewett. nigelhewett@nhs.net; if you would like further information regarding the King's Health Partners Pathway Homeless Team please contact Integration Lead Jane Cook. jane.cook@gstt.nhs.uk

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