



# **A review of the first 6 months of the pilot service**

**June 2013 to December 2013**

# **1. BACKGROUND**

## **1.1 Health and homelessness**

There is an growing body of evidence demonstrating that people who are or have been homeless experience multiple and chronic health problems at a significantly higher rate than the general population<sup>i</sup> yet these same people face barriers to accessing healthcare when and where they need it, resulting in high healthcare costs but poor health outcomes for this population group<sup>ii</sup>. Homeless people often die at much younger ages than the rest of the population, with average age of death being 40.5 years<sup>iii</sup>.

Homelessness is characterised by 'tri morbidity' – the combination of physical health, mental ill health and substance misuse<sup>iv</sup>. This complex health picture coupled with the chaos of sleeping on the streets or in insecure housing means that people don't always access the right healthcare at the right time. This can be due to structural barriers in the health system (such a GPs refusing access by asking for ID or proof of address in order to register, and attitudinal barriers (such as discrimination by health care professionals). Fear of stigmatisation and non-prioritisation of health problems by homeless patients are also factors<sup>v</sup>.

As a result **“Homeless people attend A&E up to six times as often as the general population, are admitted four times as often, and once admitted, tend to stay three times as long in hospital as they are much sicker and as a result, acute services are four times and unscheduled hospital costs are eight times those of general patients”**<sup>vi</sup>

For further reading, please see the full list of relevant publications at Appendix 3

## **1.2 Central Manchester University Hospitals NHS Foundation Trust (CMFT)**

The Trust is made up of six hospital sites and community services provision<sup>vii</sup>. Every year the Trust cares for more than 1 million people from the local community and further afield. Manchester Royal Infirmary, the City's large teaching hospital for Manchester University's Medical School provides the A&E provision for the city and sees around 145,000 patients every year, making it one of the largest A&E departments in the country.

## **1.3 Urban Village Medical Practice (UVMP)**

UVMP is a large GP practice with approximately 8,500 registered patients, offering high quality primary care services to people in Manchester city centre, Ancoats and the surrounding areas. The practice provides specialist service provision including sexual health, infectious diseases clinic, family planning, minor surgery and substance misuse services.

In addition the practice has been offering full registration and access to all primary care services to homeless people in the city for the last 15 years; the practice operates a weekly multi-disciplinary drop in and other specialist homeless clinics throughout the week for homeless people. The practice currently has approximately 620 homeless patients registered.

Our primary care service for homeless people endorses the 'Standards for commissioners and service providers' produced by the Faculty of Homeless Health in 2011 (revised 2013) and is actively working to meet all the standards for primary care services for homeless people<sup>viii</sup> All 'mpath' team members belong to the Faculty for Homeless and Inclusion Health, the first independent, multi-disciplinary body focussed on the health care of homeless and other multiply excluded people<sup>ix</sup>.

Urban Village Medical Practice is committed to providing high quality teaching and training to those pursuing a career in the medical industry. Each year we offer placements to 2 ST3 GP registrars and 1 ST2 GP registrar. In the last 12 months we have welcomed 1 registrar, 2 medical students, 4 public health nurses and 1 student nurse. We have also arranged placements for 3 more public health nurses and 1 social work student. Each placement receives a complete overview of the service from the Homeless Service Manager and a plan is made to enable them to meet their required learning outcomes.

## **2. DEVELOPMENT OF THE MPATH SERVICE**

In 2012, Urban Village Medical Practice was approached to undertake a 6 month pilot scoping the extent of A&E attendances by homeless people in the city from Dec 2012 to May 2013. This work showed that there were a significant number of homeless people that were frequently attending the MRI and that our model of proactive community engagement and support to access primary care resulted in 81% of frequent attenders reducing their attendances<sup>x</sup>

As a consequence of these findings, UVMP were commissioned by CMFT to undertake a 12 month pilot in order to continue to scope the extent of the issue and begin to develop and test out an innovative response to homeless people who are frequent attenders at A&E in order to reduce this, and also to offer a service to homeless people who are admitted to hospital, providing specialist advice to CMFT staff to manage the inpatient stay and reduce re admission rates where possible. The pilot service model was based on the work done by London Pathway who pioneered work in this field in recent years<sup>xi</sup>.

The 'mpath' (Manchester Pathway) pilot service went live in June 2013, based on the principles of 'Compassion, Communication and Continuity of Care'<sup>xii</sup> with an overall aspiration to improve healthcare outcomes and patient experience for homeless people who either attend A&E or are admitted to the MRI.

The service aimed to engage and include homeless people in appropriate health care, predominantly primary care and relevant specialist services especially substance misuse and mental health services.

We also felt it was crucial to improve social factors for individual patients – housing, benefits etc. which would be vital to bring about improved health outcomes and a reduction in the instability and chaos experienced by a high proportion of homeless patients.

This would involve developing an integrated care approach to patient care including housing, social services and third sector agencies working with homeless people. It also gave us the opportunity to improve partnership working between acute health care services and primary and community care.

In addition, we also agreed to report on the impact service had on;

- Reduced A&E attendances for homeless people that had attended A&E 12 times or more in the previous 12 months
- Reduced re admissions for homeless patients
- Increasing access to primary care for all homeless people attending A&E

In order to achieve the principles of Compassion, Communication and Continuity of Care, the service has 3 core components to its service delivery model;

### **Acute hospital rounds**

The 'mpath' hospital round is led by two of UVMP's GPs, who are experienced in providing specialist primary healthcare for homeless people, and supported by the Homeless Liaison Nurse and 'mpath' Service Manager. The hospital round regularly visits every homeless patient admitted to the MRI to co-ordinate all aspects of care whilst the patient is in hospital, offering specialist advice where required and working with hospital and community staff to facilitate an appropriate discharge.

### **Primary care follow up**

Whilst not directly funded as part of the pilot, all homeless patients identified via the service can register with UVMP and access the existing primary care services including a weekly multi-disciplinary drop in session offering access to GPs, practice nurses, leg ulcer dressings, drug and alcohol services, mental health services and a dentist as well as dedicated GP/nurse clinics for homeless people throughout the week. Homeless patients can access the full range of specialist services on offer at the practice including sexual health and infectious diseases clinics.

### **Community follow up and support**

Linked to above, our Specialist Case Managers are experienced in working with homeless people and substance misuse and work proactively and flexibly to engage frequent A&E attenders in the community and support them with issues including housing, benefits, accessing appropriate healthcare and any other issues that contribute to frequent attendance at the MRI. They will also work with people who are admitted to the MRI who have on going complex health needs or are frequently admitted. They work in close collaboration with other agencies in the city to ensure a robust and comprehensive response to the identified needs of the person. These workers also provide a twice weekly drop in session at a local homeless drop in centre that MRI staff can signpost homeless patients to.

In addition we feel that the following is a fundamental component of future success;

### **Multi-disciplinary and interagency engagement and communication**

We understand that in order to achieve better outcomes for the people we see at the hospital, we need to have robust positive working relationships with a diverse range of agencies across the city – we cannot do this work alone. We have therefore developed two strands to our partnership working;

- **Multi-disciplinary working within the MRI**

We have established a weekly meeting to discuss and agree our shared response to patients who regularly attend the MRI. Members include medical staff from the Emergency Dep't, Rapid Response Discharge Team Leader, and members of the Alcohol and Psychiatric Liaison Teams. We use this forum to develop shared 'management plans' in order to implement a unified response to patients when they present at the hospital where this is needed.

We also continue to meet with MRI staff via team meetings and other forums to provide awareness of our service; we have delivered sessions on homelessness and healthcare to medical and nursing staff.

- **Strategic interagency working**

We established a multi-agency steering group at the beginning of the pilot as we recognised that innovative solutions would require a whole system sign up. This has resulted in a planned multi-agency workshop in Feb 2014 to discuss new models of working to inform the 'Single Complex Adults' work stream of the Living Longer, Living Better framework shortly to be introduced in the city<sup>xiii</sup>

### **3. INITIAL FINDINGS – REPORT ON THE FIRST SIX MONTHS OF THE PILOT**

#### **3.1 Homeless patient activity in MRI**

The initial six month period enabled us to perform a more detailed analysis of the activity and characteristics of homeless patients attending or being admitted to Manchester Royal Infirmary, this would further inform the development of the service. To be able to do this we had to define what we classified as a homeless person.

The service uses a broad definition of homelessness that includes;

- no fixed abode/rough sleeper
- residing in designated homeless accommodation (as defined by Manchester city council) including hostels, bed and breakfasts, specialist supported establishments etc
- sofa surfing/transient living arrangements
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**499** individual patients were identified in the six month period as being homeless and attending Manchester royal infirmary, and they accounted for the following activity.

- **1506 A&E attendances**
- **371 admissions to hospital**
- **1841 bed days**

Therefore we were able to calculate the following;

- **The average annual A&E attendance of a homeless patient is 3 x a year**
- **1 in 4 attendances results in an admission to hospital**
- **The average number of bed days for a homeless patient is 5 days**

#### **3.2 High frequency users**

CMFT compile a list every month of the patients who most frequently attend the A&E department, it is a cumulative list of total attendances for individual patients in the last 12

months. The mpath service analysed the top 100 most frequent attenders and identified which patients were homeless, we used this as a starting point to identify the individuals that are attending most frequently and aimed to;

- ✓ Quantify the use of primary and secondary healthcare by this cohort of the local population
- ✓ Engage and assertively work with the individuals identified and analyse outcomes achieved for this cohort

At the start of the mpath service in **June 2013** our initial analysis of the 'top 100' list showed that;

- **29 % (29 patients ) of the top 100 were homeless**
- **this cohort accounted for 641 A&E attendances in 12 months**
- **the average attendance rate was 22 x in 12 months**
- **a total of 64 admissions to hospital**
- **a total of 173 bed days**

If we perform a comparative analysis with the data on all homeless patients activity at the MRI we can deduce that;

- **this cohort of high frequency users account for 2.9% of all homeless patients attending the MRI in 12 months and**
- **20% of the A&E activity of homeless patients in the MRI**
- **10 % of hospital admissions for homeless patients**
- **5% of total bed days for homeless patients**

It is obvious from this analysis that the service should target resources appropriately with this cohort of the homeless population to achieve optimal outcomes.

### **3.3 Characteristics of the population**

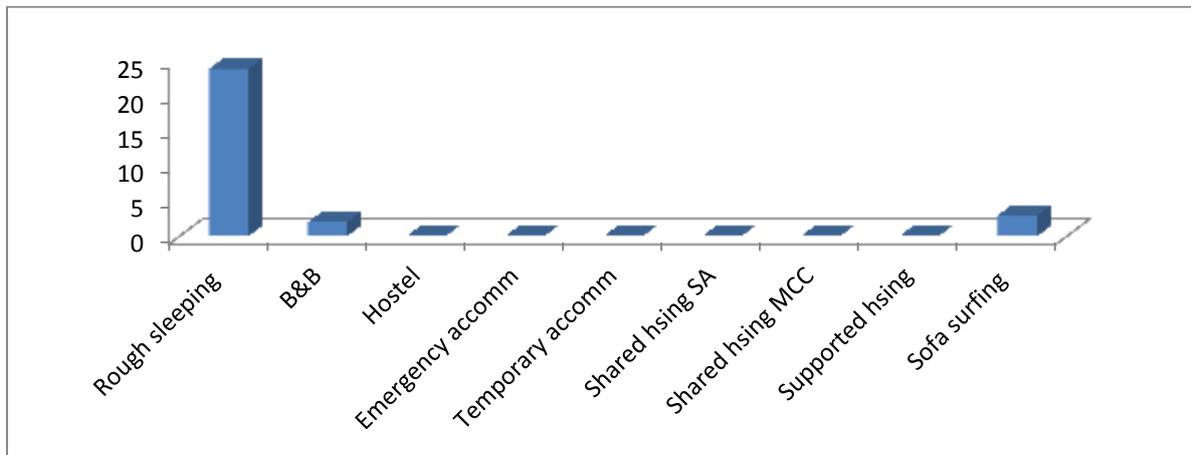
The service aimed to analyse the characteristics of this population which may be contributing to their high usage of hospital services, to enable us develop the service to respond to unmet need in the population. It also allowed us to profile patients and identify risk features of a high frequency attender.

- 70 % of patients were male and 30 % female
- 83 % were rough sleepers/NFA
- average age was 41-50 years
- 76 % were alcohol dependent
- 82 % attendances were secondary to an alcohol related health problem
- 49 % had a mental health problem

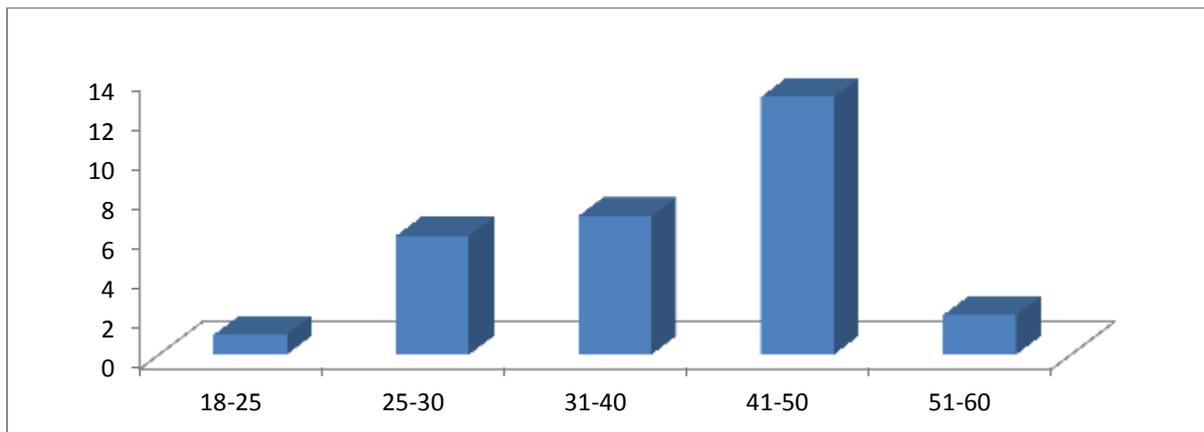
An analysis of presenting issues for this cohort when attending A&E shows that the main reasons were;

- Alcohol intoxication
- Alcohol related injuries
- Leg ulcers
- Being found collapsed due to alcohol/drug use and ambulance being called by passer by
- Self-harm

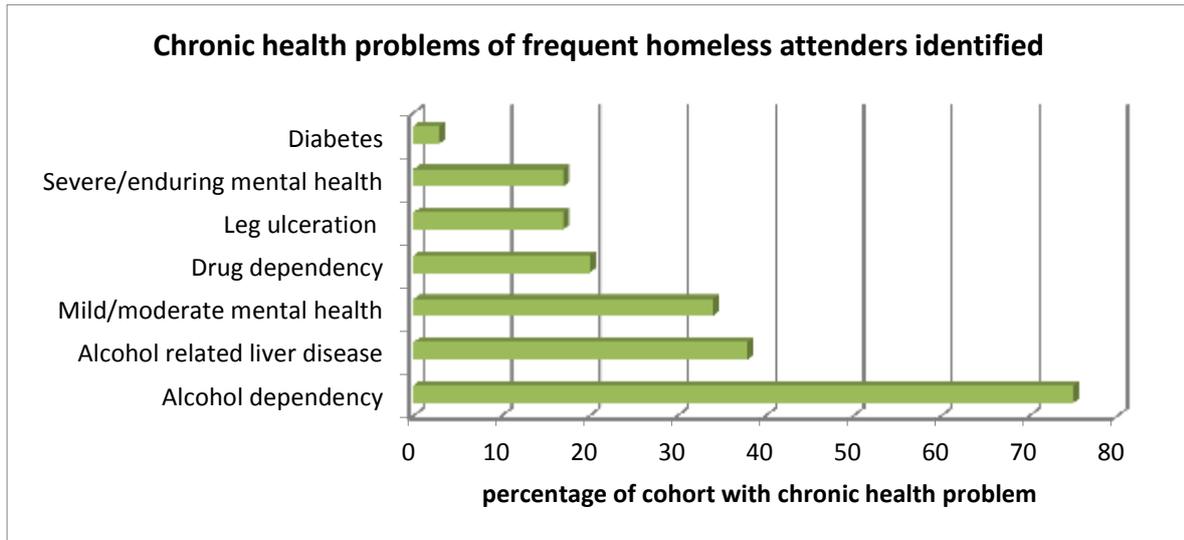
The reported housing status of high frequency user is shown in the graph below



The age range of the high frequency users is shown below



The chronic health problems of high frequency users are shown below;



NB. Many individuals have one or more of the chronic health problems shown.

In an attempt to summarise these findings, the typical profile of a homeless patient who is a high frequency user of the MRI is;

- a middle aged male who is alcohol dependent, has significant physical health problems secondary to alcohol and is of no fixed abode

The mpath service has developed its service delivery to optimally intervene with this type of individual.

### 3.4 Summary

This analysis has demonstrated that a significant number of homeless patients are attending the MRI and they generate a significant amount of activity. The homeless patient represents an individual who has a high likelihood of significant chronic health problems and an unstable chaotic existence and as a result is at high risk of unplanned usage of acute health services. A small cohort of high frequency users generates a high proportion of A&E attendances and subsequent admissions and bed days. We feel that this analysis demonstrates that this population warrants a dedicated specialist service to improve outcomes and reduce health care costs in the population.

#### **4. MPATH SERVICE ACTIVITY**

<b>June 2013 to December 2013</b>	
Frequent A&E attenders identified by mpath service	<b>55</b>
No. of assessments undertaken by the service at the MRI	<b>178</b>
No. of people who received community case management input	<b>110</b>

This data demonstrates a significant level of mpath service activity in both the hospital and community settings.

##### **4.1 Outcomes achieved by the mpath service in the first 6 months**

In June 2013 when the service started, we were able to identify a cohort of patients who were homeless and had recorded activity at the MRI for the preceding 12 months. These were the high frequency users detailed in the previous section.

We agreed that it would be appropriate that the new service would work with these individuals and analyse the outcomes in activity compared to the time period when no service existed. This would give us the best opportunity to demonstrate the effectiveness of the service. The cohort of 29 patients identified in June 2013 were assertively engaged with and followed through for the following six months to Dec 2013 and a comparative analysis made of both 6 month periods. The results are as follows:

<b>Attendance/admissions at MRI</b>	<b>June 2013</b>	<b>Dec 2013</b>	<b>% change</b>
Number of cohort in top 100 attenders list	29	15	DOWN 48%
Total number of attendances by cohort	641	338	DOWN 47%
Total number of admissions by cohort	64	33	DOWN 48%
Total number of bed days by cohort	173	105	DOWN 39%
Total number of readmissions within 28 days	23	7	DOWN 59%
<b>Engagement with primary care</b>	<b>June 2013</b>	<b>Dec 2013</b>	<b>% change</b>
Number of cohort engaged with mpath service	0	26	UP 89%
Number of cohort registered with Urban Village Medical Practice (UVMP)	11	24	UP 82%

Number of cohort that received New Patient Health Check from UVMP (indicating engagement with primary care)	9	23	UP 48%
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This comparative data clearly demonstrates that the MPATH service was able to engage these chaotic individuals and bring about a significant change in how they access health care. This resulted in a reduced unplanned patient activity at the MRI and increased access to primary and community health services, mainly through registration at the Urban Village Medical Practice and access to the multidisciplinary team based there, which includes substance misuse and mental health services.

These benefits will be felt by the health service but more importantly by the patients themselves.

#### 4.2 Improved social outcomes for patients

##### **68% of this cohort achieved a positive housing change**

This could include moving from sleeping rough to being in a hostel, or moving from a hostel to more supported accommodation or a permanent tenancy

##### **76 % of patients achieved a positive change in financial status**

This would include patients in receipt of no benefits achieving some form of benefit, or patients with inappropriate benefits changing to more appropriate i.e. JSA to PIP.

##### **63 % of this population achieved an alcohol intervention**

This could include contact/ongoing engagement with the Community Alcohol Team or detox or being placed in a 'dry' house for the cohort that were alcohol dependant

This demonstrates the importance of these interventions by the mpath service in helping very chaotic individual patients achieve a more stable existence and more positive outcomes.

### **4.3 Analysis at 12 months of original cohort**

A 12 month analysis in June 2014 revealed that

**73 % of the 29 high frequency using patients have stopped going to  
A&E\***

(\*defined as not having attended for at least 3 months)

### **5. Qualitative analysis of service delivery**

It is vital that the service is patient centred and analyses patient experiences. To achieve this we have collated both individual case studies and patients views.

#### **Patient feedback**

The service is continuously surveying patient's views of their experience when we work with them, these have been overwhelmingly positive indicating that we improve patients experience of the health service. Examples of quotes from patients can be found in the Appendix 1

#### **Case studies**

The case studies illustrate in more detail the patient experience but also how the mpath service engaged and intervened with patients to bring about positive change. They enable interested parties to understand the day to day workings of the service and how patients receive the service

Examples of case studies can be found in Appendix 2

### **6. Conclusions and next steps**

This is our initial report on the first six months of the service, we are aware that the service needs to develop further in response to the needs of our patients and we aim to use these initial positive findings for further development.

We feel that even at this early stage the service has demonstrated that it can effectively engage homeless people who present with complex needs and bring about positive change both for the individuals themselves and the wider health service. Our initial review after 6 months of the project has reinforced to us that innovative multi-agency working is crucial to achieving positive outcomes for this client group. We therefore welcome the Living Longer, Living Better framework and its anticipated implementation in the city

We have demonstrated that our interventions have brought about a reduction in impact on hospital services and an increased utilisation of primary and community health services. This has resulted in significant economic benefits for the local health economy and a justification for the financial investment in the mpath service.

We are aware that the service needs to evolve further and have been developing ideas and how to achieve this. These include;

- ✓ Closer working with the housing department Manchester city council and other third sector housing providers such that we can get faster more definitive plans for patients
- ✓ Closer working with alcohol services, to bring about a more assertive approach to people who experience severe alcohol dependency problems
- ✓ Further training and development within the hospital environment to help hospital staff and departments have an improved response to homeless patients. The current service is 9-5 Monday to Friday, many patients attend the MRI out of hours so do not receive our specialist service input.
- ✓ We feel the findings of the pilot should be shared with stakeholders to facilitate development of existing or new services
- ✓ Increased service user/patient involvement – capturing and developing their ideas about how the service should be delivered.

## APPENDIX 1

### What people engaged by the mpath service say about us

*"Staff help out in anyway that they can with treatment and homelessness and give the right advice. I can get everything from one place and I don't have to keep to appointment times. When I first came I had been on medication that wasn't helping me, the doctor at the surgery wouldn't prescribe it which was actually better for me"*

*I feel they helped me.. All my other doctors were just "here's your pills" whereas here they will help you see what you don't want to be on. For 5 years I was pumped up on medication now I'm more aware of what's going on. My family said they can see the difference"*

*"I now have access to leg ulcer clinics on a regular basis which is helping my legs to heal. I can also access other treatments such as doctor, dentist and drug worker. There are support workers who help with housing and transport to get me to appointments."*

*"Phil arranged for me to stay in hospital until my leg was better. I haven't been since."*

*"All the other times I signed myself out before I got help. I was there 3.5 weeks (this time) and was so well looked after. Then I was brought to UVMP by mpath and things got better from there. I came off Diazepam and other medication and my lifestyle got better. I had nowhere to live and they found me somewhere to stay temporarily and then moved me to another place. They helped me get in with a GP instead of going to the hospital"*

*"They're respectful and good people. They know what they're talking about"*

*"They are easy to talk to - when they explain something its clearer so you can understand it more easily. They explained the treatment I was going to need and why"*

## **APPENDIX 2**

### **CASE STUDIES**

**JAMES** is a 28 yr old Roma male who was sleeping rough and injecting drugs and funding his drug use by begging at the nearby train station. James had attended A&E 24 times in the previous 12 months and had been admitted 6 times – due to complications of injecting drugs but also for warmth and shelter overnight. James tended to take his own discharge before successful treatment of his physical health and so he kept returning. At this point James had no GP, was not engaged with drug services, had no benefit in place and no plan for accommodation.

Over a period of a couple of months, one of our case managers traced him in the community and made repeated attempts to engage James without success. However, when James was admitted to hospital again, the case worker and the GP were able to establish a rapport with James and negotiate with him to remain in hospital to complete his treatment, by establishing him on treatment for his drug problem whilst he was there, explaining the consequences of not completing the treatment for his physical health issues during his current stay and liaising closely with the ward staff during the whole of his stay.

During this time, the Case Manager worked with James to prepare for an effective and safe discharge – this included registering with UVMP and supporting James to attend the drop in sessions and setting up the continuation of drug treatment at the practice as well as facilitating a benefit claim and a homelessness assessment which resulted in temporary accommodation.

James remained engaged with drug treatment and the mpath service following discharge and has not returned to the MRI since. Twelve weeks following discharge James felt in a position to make contact with his family again and made the decision to move to live with them. The practice facilitated the transfer of his treatment and identified a local GP practice. James has not returned to Manchester.

**STANLEY**, a 54 year old male had been living in a local bed and breakfast for a number of years and was alcohol dependent. He had attended A&E 8 times and been admitted 6 times – all due to alcohol related health problems including seizures, injuries, gastroenterological problems.

Stanley had a GP but he felt unable to travel there and so had not been for over 6 months. He had also not attended for a medical assessment for his benefits and was therefore at risk of losing his benefits and consequently his accommodation. Although Stanley had had some contact with community alcohol services, he had missed a number of appointments and his case had therefore been closed.

One of our case managers visited Stanley at his accommodation after he was identified by the service as a frequent attender at A&E and developed a plan with him; Stanley registered with UVMP which was near to his accommodation – this enabled him to re-engage with alcohol services via our drop in clinics which resulted in a planned detox and subsequent placement in a

dry house. Stanley also engaged with the primary care service which resulted in him receiving sick notes which in turn reinstated his benefits and secure his accommodation.

Stanley significantly reduced his attendances at A&E during this time and increased his use of primary care. Stanley remains in a dry house and has not attended the MRI for 3 months

**ANDREAS** is a 32 year old Polish national who was rough sleeping in Manchester city centre. Andreas speaks little English. He has been resident in the UK for more than three years; he had been working and living in accommodation paid for by his employers. However, 12 months ago he suffered a work place injury which resulted in a lower leg fracture and his first admission to hospital. During this admission, he was evicted from his accommodation (as he could not work) and was discharged to the streets. Andreas survived by occasionally staying with other Polish nationals and getting food and clothing from charities.

Unfortunately, complications with his fracture resulted in 3 further admissions in the following months and Andreas was referred to the mpath team on his fourth admission with an infected tibia and fibula fracture. The decision was taken to perform a below knee amputation which resulted in a prolonged in patient stay.

During this time, the team was able to secure some short term accommodation for Andreas to go to on discharge. Andreas is also registered with UVMP and has engaged with the GP for follow up and pain relief. Although Andreas is not entitled to sickness benefits in this country, he remains healthy and now has a prosthetic limb which he hopes will enable to him to start looking for work soon. Andreas has not been readmitted since his last stay.

**Alan** is a 38 year old male who has been rough sleeping in Manchester intermittently for over 17 years. He has a long history of IV drug use and prior to registering with the practice had only ever been in drug treatment for a few weeks at a time. Alan begs in the city centre and had been engaged by an assessment worker at ADS who was actively trying to get him into drug treatment, the assessment worker introduced Alan to the UVMP Homeless Service Link Worker in an attempt to get him registered with a GP to address his multiple health concerns and to prevent him from accessing inappropriate healthcare. Alan was discussed as part of the multi-disciplinary team meeting for frontline workers and all services agreed to proactively target Alan on outreach to reaffirm the importance of engaging with healthcare services. He successfully completed the drug assessment and the worker arranged for him to see the Link Worker to register at Urban Village Medical Practice. Alan was provided with an appointment to attend the drop in a few days later but failed to attend. Again Alan was targeted on outreach by all services and 2 weeks later came to the homeless drop in where he was provided with a full new patient health check, provided a urine sample for drug screening, had his leg ulcers dressed and saw a GP for a review and not fit for work letter to commence a benefit claim with support from a worker at the Council's Begging and Street Homeless Team. 1 week later Alan attended the drop in again to receive the results of his blood and urine screen and commenced

methadone treatment with a GP. Alan was assigned to the drug worker who specialises in engaging the most entrenched rough sleepers and with his support managed to maintain drug treatment and also regularly attended the leg ulcer clinic. Alan attributes his ability to stay on a script to the dedication of the outreach team to ensure he engaged in services, the non-judgmental attitude of the staff and the flexibility of appointments reporting:

*“No other doctor would send out people to see me on the streets to check on me and to make sure I’m attending appointments and picking up my script. Every worker who sees me knows what is going on with my health and encourages me to attend the surgery. The drop in means I don’t have to keep to appointment times and if I miss my script pick up day I will always be seen by a doctor or drug worker when I come in. I’ve definitely attended hospital less since registering with the doctor because I can get everything done in one place and when I have had to go the doctors have fought for me to receive proper care in hospital”*

In October 2013 Alan was diagnosed with renal failure, the GP liaised with the renal team at MRI to ensure they were fully aware of Alan’s lifestyle and difficulty making and keeping appointments and advocated for him to be provided with a flexible service. Several appointments were made for Alan at the renal clinic and support to get to appointments was arranged, unfortunately B didn’t make any of the appointments however, in January he attended A&E with severe leg pain and the ‘mpath’ team were able to visit him in hospital and negotiated with the hospital medical staff to get Alan transferred and admitted to the renal ward. This allowed the staff to complete the tests they had been unable to do so far and to fully ascertain the extent of renal damage. Alan is still currently on the ward and the ‘mpath’ team visit him on their daily ward round and have helped him to keep his benefits in place, provide him with anything he needs to make his stay more manageable and have ensured there is an effective discharge plan in place for him in terms of accommodation.

Alan says:

*“the doctors have not hidden anything from me and have given me all the facts about why it is so important for me to stay in hospital as I normally leave before I’m discharged. They really fight my corner and I don’t feel the same prejudice in hospital as I have before, now I’m treated with respect”*

## **APPENDIX 3**

### **References**

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- vii [www.cmft.nhs.uk](http://www.cmft.nhs.uk)
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