Hull Royal Infirmary

Pathway Homeless Health team

First year report

October 2019 – September 2020

Bevan Healthcare
Health – Hope – Humanity

Hull and East Yorkshire Hospitals NHS Trust

Executive Summary

Hull Clinical Commissioning Group (Hull CCG) selected and commissioned Bevan Healthcare CIC to establish a 'Pathway' model homeless discharge service in 2019. Pathway is a health charity that has developed an integrated in-hospital care model to attempt to address the problems of poor morbidity and mortality outcomes, and inadequate hospital discharge in people experiencing homelessness.

The Pathway model aims to ensure that homeless patients get better, more appropriate care while in hospital, and are linked-in to support services for better recovery after discharge from hospital. The Pathway approach seeks to change outcomes by intervening in the cycle that leads homeless people to end up in hospital repeatedly, and helping them to take the final step away from homelessness to access the support they need. The Hull service started on 1st October 2019, and is based within the Hull Royal Infirmary's Discharge Hub. The team manages people identified as homeless in Accident and Emergency or after admission to Hull Royal Infirmary or Castle Hill Hospitals.

During the first year the team has seen 235 patients. For these patients, there has been a 77.5% decrease in rough sleeping, and an 100% increase in the number of people in secure accommodation on discharge. 21 people non-registered with a GP on admission were registered with a GP on discharge, and contact details for 83 people seen by the team were accurately updated to enable follow up.

The team has delivered on the new statutory 'Duty to Refer' with 85.5% of people eligible for referral being referred with consent. 50 frequent attenders have also been identified, with 20 receiving detailed care plans.

Hull CCG has described the team's first year as very successful. Subsequently, it has extended the Pathway team hours and staff numbers during Covid 19 to allow the team to do extra community support: this has meant further follow up in the community and supporting patients immediately post-discharge. Follow up has now become 50% of the work of the team.

The Hull Pathway team has worked with, and built relationships with, several key partners in the hospital and community to deliver the best outcomes during Covid-19. A key example of this has been work undertaken with hospital security staff. The integrated approach developed in Hull during Covid-19 has been seen as best practice, and is highlighted in this report.

Background

Aldridge et al (2018) recently found that people experiencing homelessness, people in prison, Gypsies, Travellers, and sex workers have some of the worst health outcomes in the western world. Men in these vulnerable groups were 7.9 times more likely to die, and women 11.9 times more likely to die of any cause, than those in the general population. The Office of National Statistics has also demonstrated that the mean average age of death in 2018 was 45 for men and 43 for women (ONS, 2019). Causes of these poor health outcomes are both a lack of access to primary health care, mental health and addictions care, and a lack of secure housing.

Pathway teams have been shown to improve the long-term health and housing outcomes of people experiencing homelessness when they are admitted to hospital, whilst also improving hospital capacity and being cost effective (Hewett at al, 2012; MPath, 2013; Homeless Link, 2015; Hewett at al, 2016; Dorney-Smith et al, 2016; Wyatt, 2017; Khan et al, 2019; Bristol Pathway Team, 2019). The aim of Pathway teams is to maximise the benefit of a hospital admission, and use it as a chance to set people on the road to recovery.

This report outlines the first year of operation of the Hull Pathway team which commenced operation on 1st October 2019.

Service Description

Team makeup

The Hull Pathway team is made up of one full time Band 7 nurse (Anna Darwick), two GP sessions per week (covered by two GPs Dr Ros Davies and Dr Lucy Chiddick), and two full time Health Support workers (Carly Richardson and Laura Gunstead). The staff team are close and supportive, and the service benefits from the fact that the staff were already known to the patients and other professionals in the Hull homeless sector from prior work association. The team provides cover Monday-Friday 9-5pm.

The team also has two other health support workers (advanced Nurse practitioner Julie Story, and Sue Robertson) who currently work in the Covid Protect facility and in the community.

The size of this team is an extension of the original contract. Hull CCG extended the Pathway team hours to cover extra community support, with a contract variation to extend the remit of the team. Hull CCG have been keen to develop a Brighton (Pathway plus) model where support is extended out into the community.

What does the team do?

The team undertakes an assessment spanning physical and mental health needs; housing and residency; safeguarding; social support needs and anything else deemed relevant.

This information is gathered to inform the co-production of a bespoke care plan for the appropriate discharge of the patient, prioritising their needs, concerns and aspirations. The care planning is then delivered using a sensitive, compassionate and motivational approach, in partnership with other hospital and community staff across a variety of statutory and voluntary sector agencies. Equal priority is given to the provision of appropriate housing, and linking patients into appropriate health care.

Patients are supported to register with a GP for on-going care, as well as referred and signposted to support with specialist community services to provide ongoing help with housing, social, mental and physical health and addiction issues. Where a patient needs hands-on support immediately post discharge e.g. to manage medication, rearrange a flat, access health care, etc, this can be given. An emphasis is placed on building a positive relationship with services that will build trust and endure.

In this photo, the team facilitated bringing a patient's dog to visit him, so that he felt connected to the dog, but also happy to remain in hospital.

Overall, the service aims to support people experiencing homelessness to achieve better health outcomes, as well as provide expert advice and clinical advocacy around the relief of homelessness. The foundation of the team's approach is based on the Pathway team social franchise manual and training. This is also additionally supported by monthly calls from Pathway.

The photo below was taken at the initial team training session provided by Pathway.

Referral pathways, MDT meetings and community links

The team manages people identified as homeless in Accident and Emergency or who have been admitted to Hull Royal Infirmary or Castle Hill Hospitals.

Hospital staff are increasingly referring more patients, as the service becomes more well known. Some wards have been more engaged than others, with some still expressing concerns about the potential for delayed discharges if the team gets involved. (Note that the team approach is always to deliver safe and appropriate discharge in a timely manner, and occasionally, this may include advocating for a patient to stay a little longer in hospital).

Overall however, it is felt that hospital staff are starting to understand what the team does, and relationships are improving significantly, and feedback has been good. 235 clients have been seen during the first year. The team has been able to be very responsive to referrals throughout, with the average time to pick up a referral being only one working day.

Many team referrals also come from the community. For example, the MEAM (Making Every Adult Matter) Coalition often notifies the team when clients are admitted, so that they can be supported in hospital by the team. The Pathway team also attends the MEAM meetings, and has been able to unblock issues for MEAM clients, service managers and commissioners in relation to hospital admissions and attendances.

The team is well integrated into many other community services, and the weekly multi-disciplinary team meeting is well attended and effective. Representatives from housing, community mental health services, and Renew (community substance misuse services) regularly attend. Hospital ward staff are also invited to attend to discuss their patients, and they are being actively encouraged to get more involved. Once a month, one member of the team also attends the RSI (Rough Sleepers Initiative) meeting. The team intends get involved with a sex worker review meeting, which is due to commence soon.

Housing, Step Down and Move On

As can be noted from the outcome data, the team has had considerable success with improving housing status on discharge. From the patients seen, there has been a 77.5%

decrease in rough sleeping, and an 100% increase in the number of people in secure accommodation on discharge.

The Covid response has aided the team: a 40 bed Covid Protect facility (Endsleigh) was set up in Hull, and far more Bed & Breakfast spaces have been made available. This has provided more housing options than were previously available. However, there hasn't been the same amount of provision for women as for men, and for those with limited mobility, accessible beds are in short supply. The team has and will continue to raise the profile of this issue. Additionally, some of the most challenging clients that have been placed at the Covid Protect facility who have done well with the extra support, but have then become somewhat 'stuck'. Following the placement, there has not been a lot of supported, appropriate move-on options for them. This has been a nationwide problem. The team has been working to support these clients.

The success of the Covid Protect initiative with support of the Hull Pathway team has convinced local leaders of the need to have an ongoing specialist step down facility. A plan for a pilot step down/intermediate care facility is 'ready to go', and has approval from the CCG and the heads of adult social care. A bid to the Department of Health hospital discharge fund will hopefully prove successful in December.

Community Follow Up

Follow up support has grown as a central part of the support that the team offers, in line with the extension of the contract. As part of the original CCG contract, the team routinely provides follow up with patients at 2 weeks and 6 weeks after discharge. However, the outreach element has grown with the growth of the service, mainly due to the presence of the Covid protect facility. The team now spends 50% of its time outside of the hospital, but sees this as essential to the success of the service; particularly as this area of support has been going very well. The team are often used as a stop-gap support service, when other services don't have the capacity to see all their own clients regularly, but extra support is required on discharge. This community bridging type approach is a key ambition for the Pathway charity, and it is very pleased to see this working so well in Hull.

All clients seen by the team have their GP registration checked. 21 clients not registered on admission, were all successfully registered with a GP on discharge.

The team also updated the records of 83 clients to enable hospital appointment letters to go to the correct address. The team has tried to encourage the routine updating of patient addresses on admission alongside some of the hospitals' switch to electronic records. The team currently visits all patients with HMP listed as their admission address, as they are often homeless.

Frequent attendance

50 patients seen by the team were identified to be frequent attenders to the hospital. 20 had frequent attender plans written and shared with A&E (40%). It is hoped that more will be achieved in this area next year.

Safety and Governance

The team has done a lot of work with Adult Social Care and Safeguarding – escalating issues from within the hospital. They have identified some important hospital wide issues, such as security staff being inappropriately used to manage / contain patients under a DOLS order (Deprivation of Liberty Safeguards).

16 of the 235 patients were still discharged to the street despite input and the best efforts from the team. An audit is being undertaken to review all these cases, and examine what else could have been done.

9 deaths occurred within these of 235 patients during the year. This demonstrates the underlying morbidity in the group. Two of the patient deaths were among the 16 discharged to the street, and they were both referred to the safeguarding adults review board by the team. Two people have died in the hospital, and the team were there to support them. One death was a suicide.

The team very much sees reduction in discharges to the street, deaths, and self-discharges, as its core purpose. Several management and operational plans have been undertaken, and more are planned to improve hospital safeguarding processes for this group. There have been concerns that patients with safeguarding issues who oscillate between hospital and community are not having their needs met, as hospital staff and safeguarding teams are primarily concerned about the risk within the hospital, but the risk in the community seen to somewhat as 'belonging' to social care or community services. The team is trying to tackle the issue of frequent attenders, and is striving to encourage more robust procedures to be in place, particularly from A&E.

Hospital Culture

The team has focused initially on building relationships with the hospital security team. They have been trained on Pathway service objectives, and encouraged to communicate with the Pathway team as a key partner. There are plans to do more training with the security team, and build their expertise. It is felt that security have previously been asked to do a lot of 'gatekeeping' and have prevented some homeless patients coming to A&E (thinking they have been doing the right thing). This new partnership is proving successful to both sides. This work has been recognised by Pathway's charity management as being very important. Pathway now plan to add a section on 'working with security teams' as part of the social franchise manual guidance.

The team are also working more generally on hospital culture, and take any opportunity they can to educate – either in small groups or in a 1:1 scenario.

43 (18%) out of 235 clients self-discharged despite input from the team. This is a real concern. The team's outcomes suggest that those that have been discharged *with* the full support of the team have improved their health and housing outcomes significantly. In fact, self-discharge is not unusual in this client group with many hospitals reporting rates of between 20% and 30%. However, it is important to note that the background rate of self-discharge in the general population is around 1.5%, so this ideally needs to be reduced. Whilst patient behavioural issues play a part in this, hospital culture is also important, and

the team will be actively monitoring and seeking to reduce self-discharge rates over the next year, by undertaking more training.

Case Studies of practice

Case study 1 – Bob (not his real name)

The team met Bob when he was released from prison after a 6-week sentence, directly to rough sleeping. He was brought in under the influence of alcohol and hypothermic, after being found in a door way by police. He had a history of injecting amphetamines and Hepatitis C, and a history of depression and self-harm. He was not registered with a GP in the local area, and not open to any substance misuse and mental health team.

When Bob was presented at A&E he had a superficial skin infection. He was referred through to the Pathway team by an A&E Dr who assessed the patient. The team immediately went to A&E to assess the patient themselves and understand his needs.

Bob did not need to be admitted to hospital, so the team put together the following plan:

- They arranged for an emergency bed (night shelter) provision which could be accessed at 8 pm
- They arranged for Bob to be allowed to wait in the Discharge Lounge until 7.30pm
- They arranged for Emmaus Rough Sleepers Outreach to meet the client and walk him to the night shelter
- They referred Bob to Renew who saw and assessed the client in regards to substance misuse issues during that day
- They referred Bob to the Assertive Engagement Team in regards to Mental Health.
- They undertook the Duty to Refer to Hull City Council. (The Housing Options Team offered him a main room in a hostel the following day)
- They provided him with clothing, and a coat and shoes and bought him food
- They alerted the probation service to the hospital episode and his placement on discharge.

This simple case study summarises the team's core work, and what it aims to achieve with every patient.

Case study 2 – Colin (not his real name)

Colin was found wandering in Hull after an assault, and was brought in to hospital by police. He was then shortly escorted off site by security due to his perceived behaviour, but could not get far due to a broken foot. He was found sitting on a bench outside, until a police officer brought him back in, where his foot fracture was diagnosed.

Colin was quite paranoid when the team first met him. He had just spent 7 months rough sleeping following his release from prison. Since coming out of prison, Colin hadn't been in touch with outreach services, his probation officer, or Renew (drug service), and as a result probation were planning on recalling him to prison. He had previously been placed in a local Covid Protect bed space from the streets, but it had broken down very quickly due to his support needs. He had had a long history of treatment and support for his mental health issues, and repeat prison sentences. Despite this, and in view of the perceived limited option, the hospital wanted to discharge him back to the streets once he had his cast on.

The team persuaded the hospital to admit Colin. They spent a lot of time with him, and did a lot of work to overcome his paranoia and distrust of services. This resulted in the mental health team prioritising, and initiating appropriate treatment for his mental health, while he was an inpatient.

The team were clear that if he was discharged to the streets his mental health would deteriorate, but he described himself to be terrified of going to a hostel, because of the types of people he thought he would meet there. The housing team offered him two hostels which he then declined, and it took lots of advocacy and persuasion to get them to keep his case open. The team also made a safeguarding referral to highlight what his vulnerability would be if he was discharged to the streets.

Eventually Colin was kept in hospital for 3 weeks, which required daily battles with medical teams on his behalf. The team spoke to him daily, got him back in touch with his mother, and eventually also with his daughter, from whom he was estranged. They also advocated

for probation to not recall him due to his increased engagement, and to take into account his support needs. Colin was eventually supported into a Bed & Breakfast.

Colin is now going from strength to strength, has a new phone, new clothes, and is taking care of himself. He is managing his medication, and doing well. Other services had previously written him off, but he is now engaging well with them, and the team feel they have transformed how other services see him which has also made a massive difference to his treatment and support.

Case study 3 - John (not his real name)

The team first met John in November 2019. He was living in a hostel, and had been in and out of hospital with problems with his liver. He was a heavy drinker, and prior heroin user. He was initially discharged to a step-down bed, but he was then moved on to an unsupported Housing Association ground floor flat. He did not want to go into a hostel.

John was proud to be given a flat. However, when one of the Pathway team members visited him there, he was sitting in a wheelchair with nothing around him, he had no possessions, nor any gas or electricity. The team member then phoned around to get donations of pots and pans and other essential household items. Unfortunately, when the team member returned to try to support him, he was heavily under the influence of alcohol, and she therefore decided she could no longer lone work with him on that day. However, she continued to support him over the phone. He was referred to Adult Social Care by the team.

John then disappeared for a few weeks before coming back into hospital. In order to support the second discharge, another team member helped him clean the flat, which had become infested with maggots, and obtained a washing machine for him and sorted out his benefits. By this time the Housing Association said they were going to 'end his tenancy, and put him into a hostel'. However, the lead nurse then challenged this, as it was not following a legal eviction process, and not what the client wanted. The lead nurse also challenged Adult Social Care for not providing him with an adequate support to maintain his independence and live safely. Things settled for a while.

Unfortunately, John was admitted a third time. On his third discharge, he was discharged with no analgesia despite the best efforts of the team. This was a failed discharge. The team put in a Datix for the third discharge. The team doctor has followed this up, and the issues around John have been raised at several different levels, and the CCG is both aware and involved.

Overall, John spent five months in hospital over the course of the year. In the case of John, the team tried to meet needs not being met in the community by other services, and has maintained contact as a vital support for John, and liaised with other agencies on his behalf. They have also provided crisis support to maintain his safety. However, John's case revealed gaps in service that have been appropriately escalated by the team from a commissioning and strategic perspective.

Team Achievements

The team was given an 'Award for Outstanding Contribution' by Emmaus, one of their key partners, in recognition of the impact that the team has made since commencing in Hull.

The Queen's Nursing Institute Community Nursing Covid-19 Innovation Best Practice site published a nursing case study from the team, and the team has now been asked to speak at the FEANTSA (European Federation of National Organisations Working with the Homeless) conference as a result of this.

https://www.qni.org.uk/wp-content/uploads/2020/07/Anna-Darwick.pdf

Partnership working in Hull during the pandemic has been held up as an example of national best practice, and a video and webinar on this work is available to access online.

Homeless health: working together in Hull
https://www.youtube.com/watch?v=0pYcjl30-xE

Working together in Hull to end Rough Sleeping
https://drive.google.com/file/d/1M9249bviq22svgTb0DgLjVVZ4XjnZuxB/view

Data and outcomes

Referrals

276 referrals, 235 accepted.

Average time to pick up referral – 1 day

Housing outcomes

Housing status on referral

Housing Status	Number	Percentage
Rough sleeping	71	30.2
Hostel	68	28.9
Sofa surfing	38	16.2
Own tenancy or similar (threatened with eviction)	30	12.8
Step down	13	5.5
Bed and Breakfast or temporary accommodation	10	4.3

Unknown	3	1.3
Police custody	2	0.9
	235	100.0

- Number rough sleeping or in very unstable accommodation = 71+38+30 = **139**
- Number in secure accommodation = 68+13+10 = **91**
- Unknown / other = **5**

Housing status on discharge

Housing Status	**Number**	**Percentage**
Rough sleeping	16	6.8
Hostel	73	31.1
Own tenancy or similar (now secure)	43	18.3
Step down	31	13.2
Bed and breakfast temporary accommodation	23	9.8
Sofa surfing	22	9.3
Night shelter	12	5.1
Other	4	1.7
Died	4	1.7
Police custody	2	0.9
Unknown	6	2.6
	235	100.0

- Number rough sleeping or in very unstable accommodation = 16+22 = **38**
- Number in secure accommodation = 73+43+31+23+12 = **182**
- Died = **4**
- Unknown / other = **12**

Overall outcomes

- 77% reduction in rough sleeping (71 to 16)
- 88% decrease in very unstable accommodation (139 to 16)
- 100% increase in stable accommodation (91 to 182)

Self-discharge – 43 (18.3%). The clients that self-discharged were split across those returning to rough sleeping and sofa surfing, those already in hostels or secure accommodation (who returned to this), and 6 were unknown.

'Duty to Refer' Outcomes

'Duty to Refer' undertaken	**Number**	**Percentage**
Yes	130	85.5%
No	16	10.5%
Declined	6	4%
	152	100%
Not needed as already in stable accommodation	80	
No data recorded	3	

152 people theoretically were eligible for the Duty to Refer (139 people plus some of those + 13 that went to step down)

Of these 130 (85.5%) were referred, and 6 (4%) declined. 10.5% were not referred, but this was mostly people who were provided with step down accommodation.

Frequent attendance

Identified frequent attenders – 50

Frequent attender plan written – 20 (40%)

GP registration outcomes

Not registered with GP on admission – 21

Registered with GP during admission - 21 (100%)

Updating of hospital records outcomes

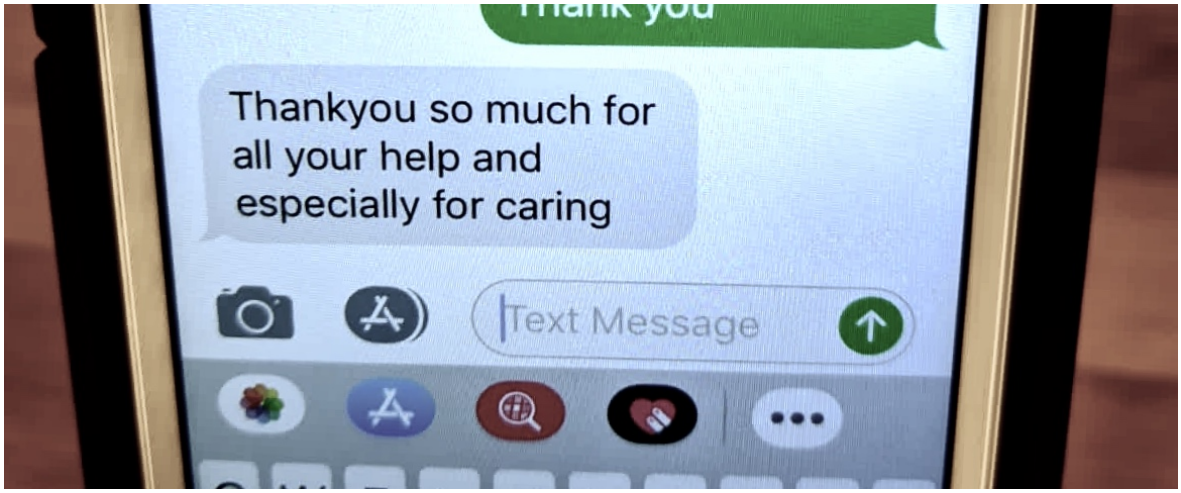
Wrong details found on hospital record – 108 (45.9% of clients seen)

Record updated – 83 (76.8%)

Staff and Client Feedback

Hull CCG is in the process of undertaking an evaluation, and results of this evaluation will be available shortly. In the meantime, here is a selection of patient and staff feedback from the last year.

Patient feedback



'I was very close to bigger problems because I'm diabetic when I came [to the hostel]. I couldn't even walk - you don't realise the implications, they helped me to do this.'

'Talking about personal stuff has made me feel connected.'

'They [the team] have given me my zest for life back!'

'You girls have made me feel human again, I actually think there is a chance for me now'..

Carer feedback

'Thank you for caring for him ladies, I mean really caring and for seeing the lad I see…'

Professionals feedback

'I had a really good session with [patient name removed] today and he speaks so highly of you three. I just wanted to pass on his thanks. He literally feels as though your team has (and I quote) 'saved his life'. You have inspired him to want to get the help and turn his life around. Well done to you guys – amazing work.'

'The best thing that I have found that this service provides, is that when a rough sleeper attends A+E a Pathways team member is always there to take care of the rough sleeper and make them feel comfortable as hospitals can be a scary place…'

'Since the Pathways team have formed people are not returning to the streets'.

'The service sees the person beneath the chaos and supports them to get the best possible care. They keep fighting for the best outcomes for that client.'

'They work well with other agencies for best outcomes for those clients.'

'Since commencing work with the service back at the start of the pandemic, I have been amazed at how proactive this service is. I have found the partnership working to be beneficial not only to the service user, but to myself as a worker, and have really come to positive outcomes with the support of this service. I have found the person-centred approach to be key, and no ask is ever too much.'

Summary and Plans for Next Year

This report has demonstrated that the new Hull Pathway team has had a significant impact in reducing the number of people returning to rough sleeping from hospital, and it has also improved partnership working between the hospital and he community in terms of the Hull response to rough sleeping. Follow up post discharge of people experiencing homelessness has also improved.

The team are, however, aware that there are many more areas in which care could be better, and plan to continually evolve to improve care further.

Plans for next year include:

- Work with hospital system leaders to put in effective processes to identify people experiencing homelessness earlier in their hospital journey
- More training to front-line staff involved in caring for people experiencing homelessness
- The development of a Hospital Link Nurse programme where nominated ward nurses could be become expert 'homeless and inclusion health champions' to support patients and their ward team
- The development of intranet resources

This team is the first Pathway Social Franchise team to meet the one year mark. Pathway are extremely proud of the achievements and progress of this Bevan Healthcare team so far, and are looking forward to an ongoing successful relationship in the future.

References

- Aldridge R et al. (2018) Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance misuse disorders in high-income countries: a systematic review and meta-analysis. The Lancet. Vol 391. January 20. 2018, pp. 241-250.

- Hewett N et al. A general practitioner and nurse led approach to improving hospital care for homeless people. BMJ 2012; 345:e5999.

- MPath. (2013) A review of the first 6 months of the pilot service. July to December 2013.

- Homeless Link (2015) Evaluation of the Homeless Hospital Discharge Fund.

- Hewett N et al. (2016) Randomised controlled trial of GP-led in-hospital management of homeless people ('Pathway'). Clin Med;16(3):223-9.

- Dorney-Smith S et al.(2016) Integrating health care for homeless people: the experience of the KHP Pathway Homeless Team. British Journal of Healthcare Management 2016;22(4):225-34.

- Wyatt L. (2017) Positive outcomes for homeless patients in UCLH Pathway programme; British Journal of Healthcare Management 2017 Vol 23 No 8: p367-371.

- Khan Z et al (2018) Improving outcomes for homeless inpatients in mental health, Housing, Care and Support, Vol. 22 Issue: 1, pp.77-90.

- Bristol Pathway Team (2019) Bristol Service Evaluation of Homeless Support Team (HST) Pilot in Bristol Royal Infirmary. Internal evaluation, presented at Faculty for Homeless and Inclusion Health Conference March 2019.

- Gazey A, Wood L, Cumming C, Chapple N, and Vallesi S (2019). Royal Perth Hospital Homelessness Team. A report on the first two and a half years of operation. Schol of Population and Global Health: University of Western Australia, Perth, Western Australia.

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