Pathway and Inclusion Health.

Alex Bax

CEO Pathway

Dr Nigel Hewett

Secretary to the Faculty for Homeless and Inclusion Health

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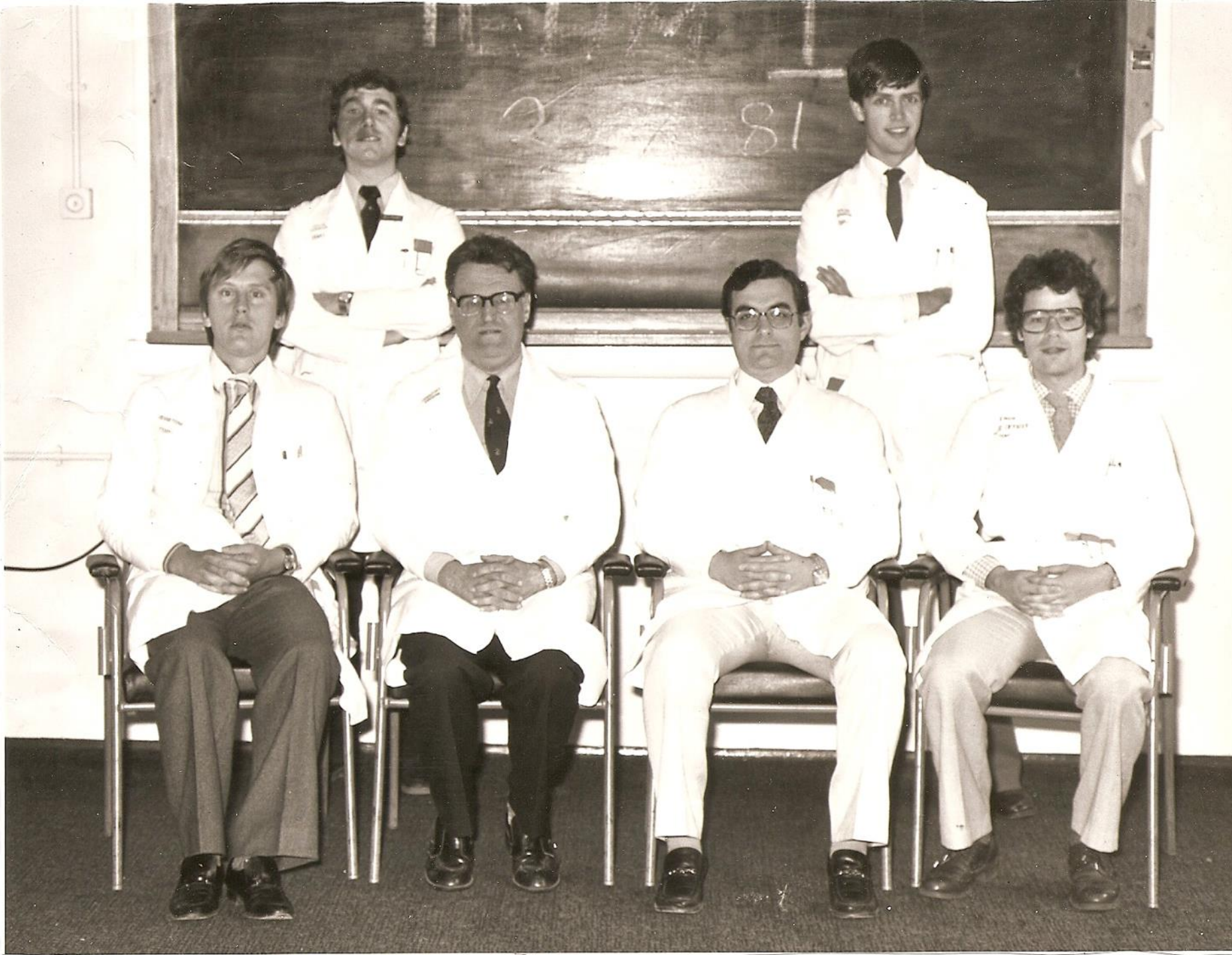

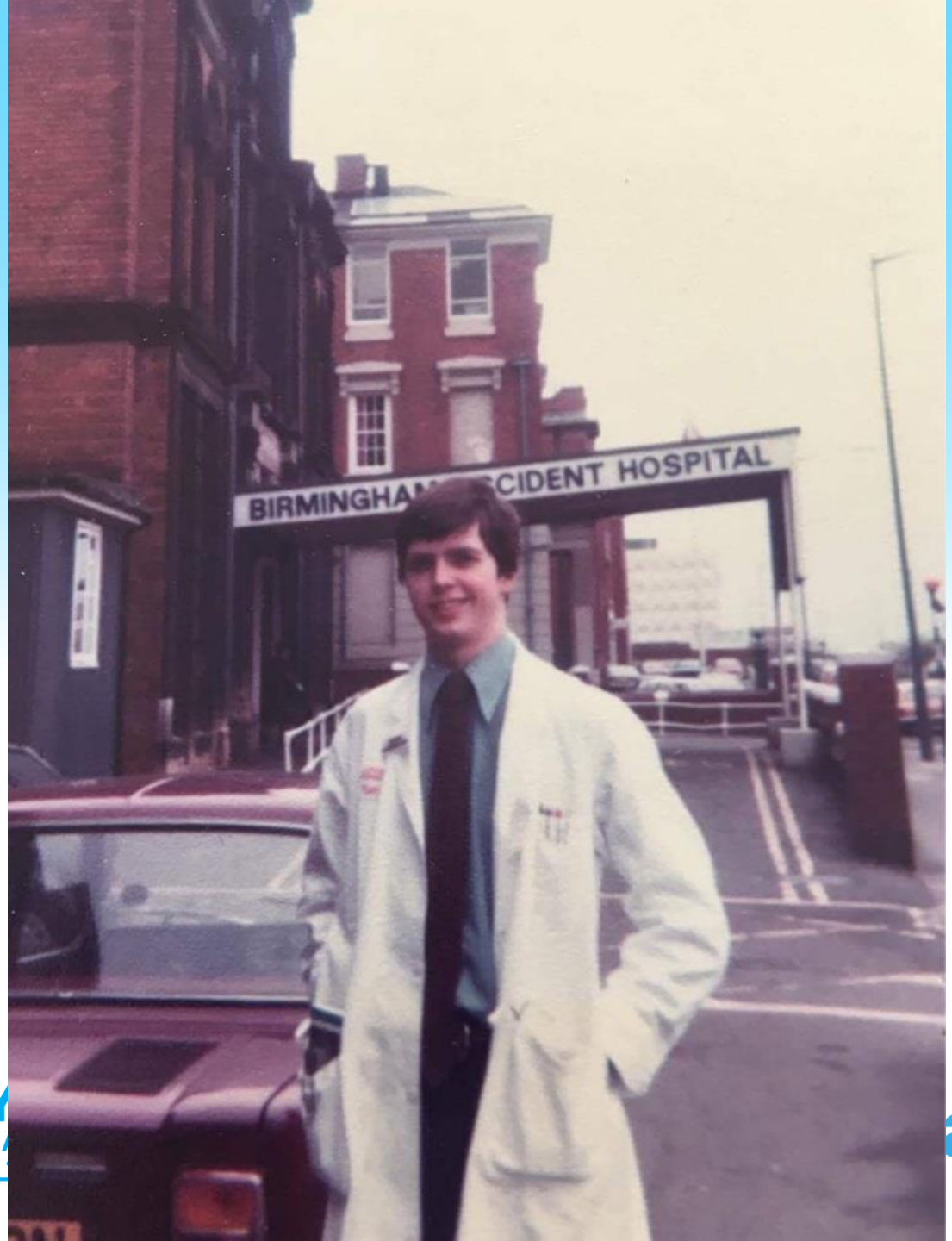

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Annual Reports keep other agencies (and funding bodies) aware of activities and progress.

In the absence of other data, your data is the best data available!

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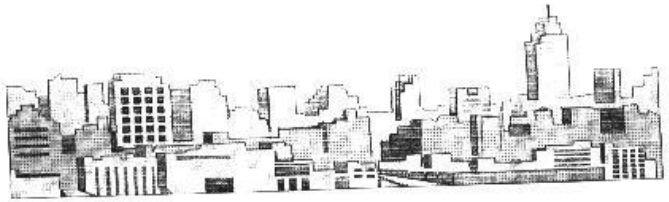
Leicester Community Homeless Service

Annual Report 1995-96



The Leicester Homeless Death List.

- **Male, 27, cause of death not listed.**
- **Male, 42, alcoholic found dead in disused house.**
- **Male, 46, found dead in ditch, depression and alcoholism.**
- **Male, 44, burned to death in disused house.**
- **Male, 44, status asthmaticus.**
- **Male, 34, hepatic renal and pulmonary failure due to paracetamol poisoning and that he did kill himself by taking an overdose.**
- **Male, 41coronary thrombosis (diabetes and self neglect.**
- **Male, 30, methadone poisoning, having purchased a bottle of methadone he ingested and caused his own death.**
- **Male, 53, acute alcohol poisoning (found dead on a bench)**
- **Female, 18, inhalation of butane gas.**
- **Male, 39, acute haemorrhagic pancreatitis.**
- **Male, 27, hypothermia and high blood levels of diazepam.**
- **Male, 57, Alcoholic, epilepsy.**

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The Leicester Homeless Death List.

- Male, 34, haematemesis due to alcoholic liver disease.
- Male, 20, dihydrocodeine poisoning.
- Male, 41, methadone, cyclizine and diazepam poisoning.
- Male, 36, morphine poisoning following heroin injection.
- Male, 42, acute left ventricular failure due to coronary atheroma.
- Male, 28, fatal heroin overdose.
- Male, 17, methadone toxicity.
- Male, 23, multiorgan failure, heroin misuse. Male, 22, acute methadone poisoning, found in bin shed, Dover Street. Male, 22, heroin OD, found in toilet in Oxford. Male, 74, myocardial infarction due to ischaemic heart disease due to smoking. Male, 31, heroin overdose with alcohol in night shelter. Male, 51, acute left ventricular failure due to coronary atheroma (chronic alcoholic). Male, 45, collapsed and died outside night shelter, bronchopneumonia, cirrhosis, chronic alcohol abuse. Male, 42, septic shock, bronchopneumonia, hiv infection, chronic alcoholic. Male 43, stabbed to death. Male, 29, acute pulmonary oedema. Male, 31, heroin addict, alcoholic.

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David Ogilvy

- Recruit people who are better than you, then step back and take the credit
- Because the alternative is to do the opposite, step up and take the blame

inclusion healthcare

CQC “Outstanding” November 2014
“I am delighted to highlight the exceptional standard of care which is being provided by Inclusion Healthcare. The service has a clear vision to improve the health of vulnerable and excluded groups - such as homeless people, refugees or those with learning disabilities.
Professor Steve Field, Chief Inspector of General Practice

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3rd International Street Medicine Conference Houston Texas 2007

University College London Hospital

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Pathway hospital team

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- Pathway believes that chaotic homeless patients provide an ideal stress test for our systems, revealing gaps in services and breakdowns in communication. This offers the opportunity that by improving the care of homeless patients we may improve systems that benefit all of our patients.

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Homelessness & ‘Tri-morbidity’

- **Substance misuse** - > 60% history of substance misuse
- **Mental health** - 70% reach criteria for personality disorder
- **Physical health** - >80% at least 1 health problem, 20% > 3 health problems

- **Onset of related functional impairment 10-15 years early**

Consequences of high inequality, child poverty, childhood trauma, austerity….

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Pathway – what is the evidence?

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Evidence for the Pathway model

- First team launched 2009
- Rigorous evaluation built into all pilots
- Positive outcomes in all
- All Pathway teams now recurrently funded

- **Cited as best practice in NHS long term plan (p42)**

https://www.england.nhs.uk/long-term-plan/

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Evidence for the Pathway model

- Pathway improves hospital capacity by reducing average duration of admissions[1,2,5,6,7], subsequent A&E attendances[2,5,8], and readmissions[1,2,5,7,8].

- Pathway improves outcomes - better health 90 days after discharge[3], less rough sleeping[3] and improved housing outcomes on discharge[4,5,6]

- Pathway is cost effective calculated using Quality Adjusted Life Years[3], and also when comparing the costs of the team to the reduction in secondary care activity for involved patients[7,9].

Improves capacity, outcomes and is cost effective

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4. Evaluation of the Homeless Hospital Discharge Fund. Homeless Link. 2015. Available at: https://www.homeless.org.uk/sites/default/files/site-attachments/Evaluation%20of%20the%20Homeless%20Hospital%20Discharge%20Fund%20FINAL.pdf
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6. Khan Z et al (2019) Improving outcomes for homeless inpatients in mental health, Housing, Care and Support, Vol. 22 Issue: 1, pp.77-90, https://doi.org/10.1108/HCS-07-2018-0016
7. 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.
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9. 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. https:qrs.ly/bo9ldsq

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The Faculty for Homeless and Inclusion Health

Over 1400 members, including:

- Doctors
- Nurses
- Mental health professionals
- Social care professionals
- Housing workers
- Public health officials
- Commissioners
- Students
- Experts by experience
- Researchers

www.pathway.org.uk/faculty

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International Symposium on Homeless & Inclusion Health

- 300 professionals and Experts by Experience
- Speakers from across the world, past examples:
  - Professor David Nutt
  - Professor Sir Michael Marmot
  - Professor Dame Sue Bailey

10th Annual Conference March 2022

www.pathway.org.uk

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‘Inclusion health is a research, service, and policy agenda that aims to redress extreme health and social inequities among the most vulnerable and marginalised in a community.’

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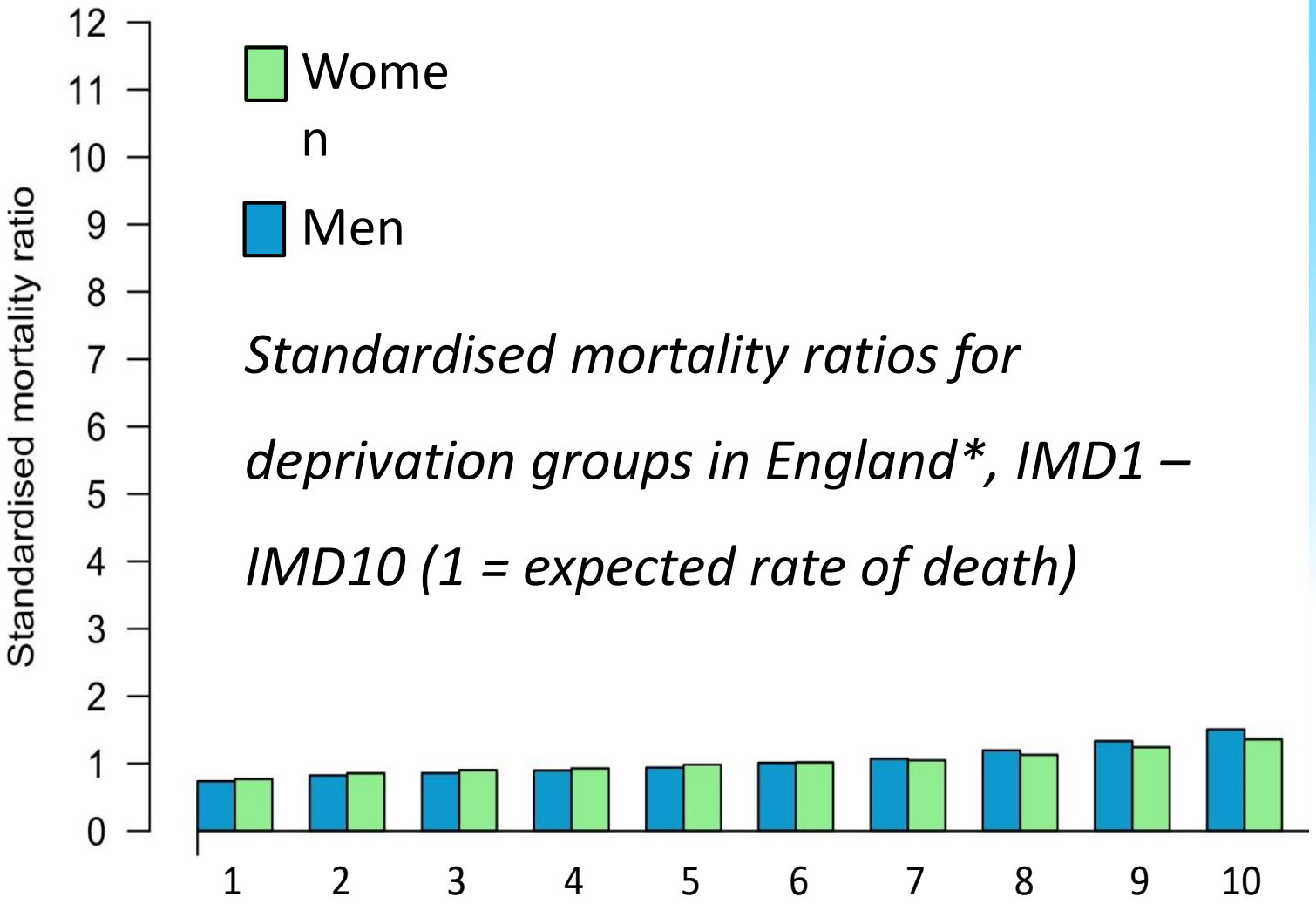

Standardised mortality ratios for deprivation groups in England, IMD1 – IMD10 (1 = expected rate of death)*

**Deaths by underlying cause, deprivation decile areas, 5 year age groups and sex, England and Wales, 1981 to 2015 Populations by deprivation decile areas, 5 year age groups and sex, England and Wales, 2001 to 2015*

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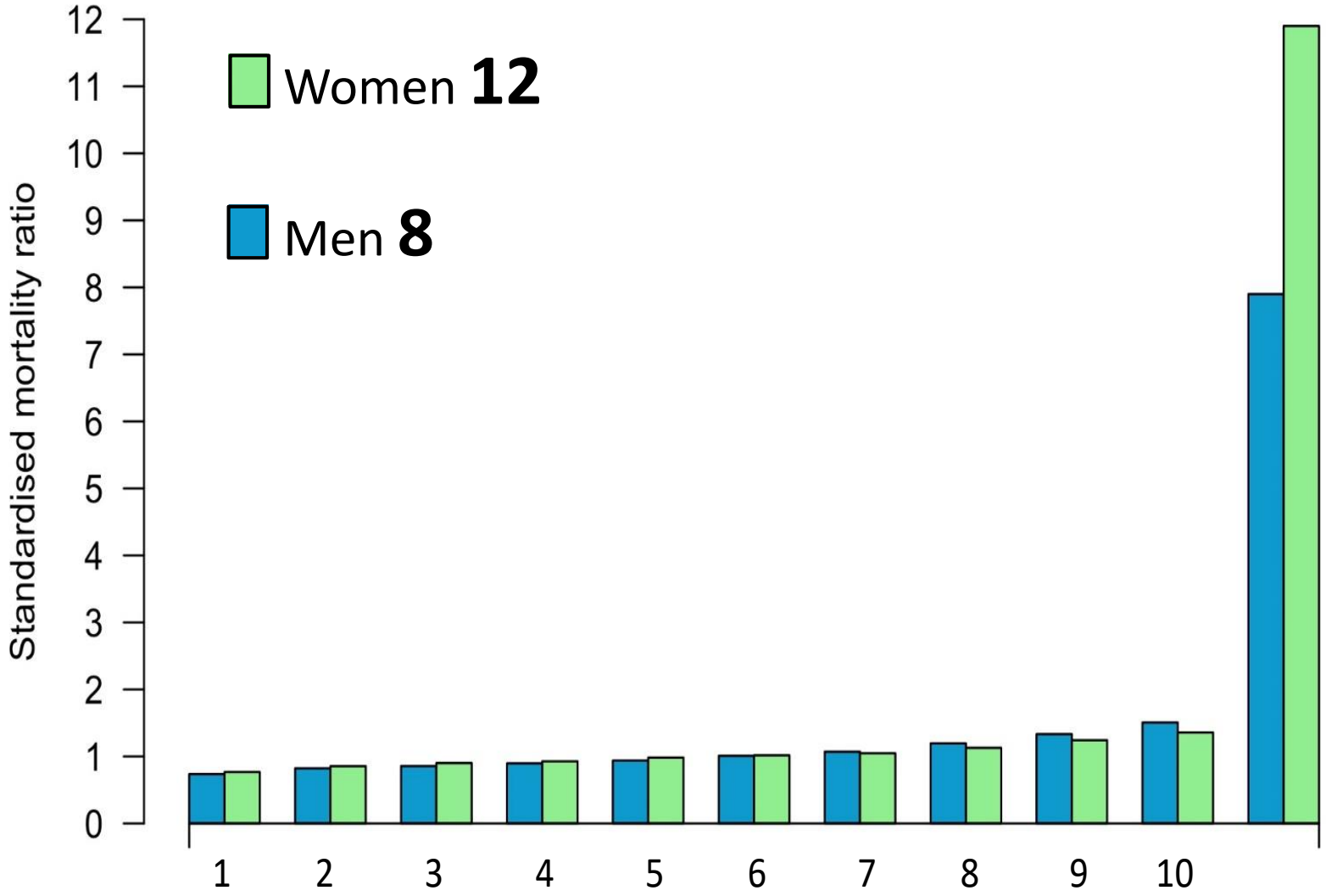

**Deaths by underlying cause, deprivation decile areas, 5 year age groups and sex, England and Wales, 1981 to 2015 Populations by deprivation decile areas, 5 year age groups and sex, England and Wales, 2001 to 2015*

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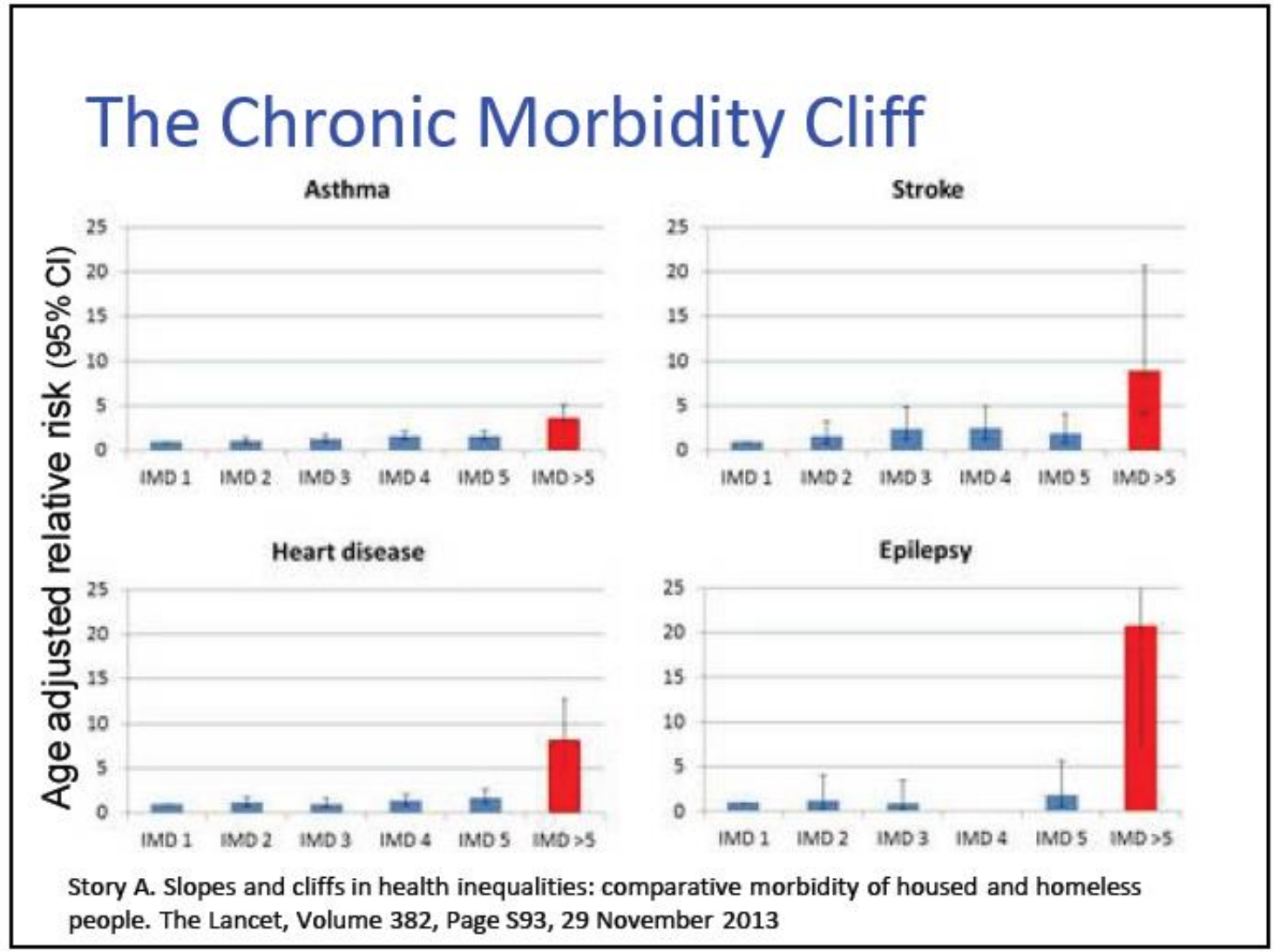
It's not just about deprivation…



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

Morbidity and mortality in homeless individuals, prisoners, sex workers, and individuals with substance use disorders in high-income countries: a systematic review and meta-analysis

Robert W Aldridge, Alistair Story, Stephen W Hwang, Merete Nordentoft, Serena A Luchenski, Greg Hartwell, Emily J Tweed, Dan Lewer, Srinivasa Vittal Katikireddi, Andrew C Hayward

What works in inclusion health: overview of effective interventions for marginalised and excluded populations

Serena Luchenski, Nick Maguire, Robert W Aldridge, Andrew Hayward, Alistair Story, Patrick Perri, James Withers, Sharon Clint, Suzanne Fitzpatrick, Nigel Hewett

The challenge is to bring socially excluded populations in from the cold—literally and metaphorically—and to provide them with the opportunity to be part of a diverse and flourishing society. *Michael Marmot*

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Academy of Medical Royal Colleges

Inclusion Health

Academy of Medical Royal Colleges and Faculty for Homeless and Inclusion Health Joint Position Statement

8 May 2017

'Inclusion health is a research, service, and policy agenda that aims to redress extreme health and social inequities among the most vulnerable and marginalised in a community.'[1]

'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.'[2]

Inclusion Health is a universal concept but responds to local needs. The Academy of Medical Royal Colleges [the Academy] and the Faculty for Homeless and Inclusion Health are committed to high-quality care for all who use the NHS. Those who are living on the margins of society are too often poorly served. We believe that care must be tailored to reflect the particular needs of each patient, with clinicians addressing the patients' total health, care and social needs.

There is a growing understanding of the impact of health inequalities on patients and healthcare providers. Whilst many people experiencing deprivation will face the health impact of inequality, this impact is particularly acute for the most marginalised. People in this situation may include homeless people, vulnerable migrants, sex workers, Gypsies and Travellers and those in contact with the criminal justice system.

The Academy and the Faculty of Homeless and Inclusion health are committed to:

- Promoting "Proportionate Universalism" – health resource distribution that favours the disadvantaged and actively reverses the "inverse care law"
- Meeting the health needs of excluded groups with respect, dignity, and compassion
- Ensuring prompt access to emergency care for all
- Offering GP registration to all who need healthcare
- Addressing cost recovery only after the patient receives urgent treatment
- Integrated care that considers patients' physical, psychological and social care needs, with complexity managed by individual care coordination supported by a multi-disciplinary team
- Empowering patients to make decisions about their health, and involving patients in the design and delivery of care
- Improving awareness that health care alone cannot transform health inequalities. It requires societal change, reducing poverty and inequality to tackle the root causes of homelessness and multiple disadvantage

'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.'

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Homeless and Inclusion Health standards for commissioners and service providers

https://www.pathway.org.uk/standards/

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Version 3.1 Published October 2018

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co-sharing
experience
communicated
conditions
preferences
ideas
collaborating
joined-up
embracing
pathways
belief
integrated
budgets
improving
team
Thinking
co-ordination
patient
collaboration
knowledge
long-term
support
goal
empathetic
GPs
user
Team
Pathways
Holistic
integration
patients
housing
Champion
Fragmented
gaps
third
Frail
inclusive
sector
delay
person
Third
clear
Housing
Communities
Plan
people
seamless
respect
consultants
trained
help
bureaucracy
care
Specialised
working
together
listening
joined
social
uncomplicated
holistic
patient-centric
professionals
input
health
service
complex
co-ordinating
meaningful
agencies
accessible
ownership
staff
outcomes

Individual care coordination supported by a multi-disciplinary team

- More than anything a trusting relationship with someone who cares

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Resources slide

- www.pathway.org.uk/faculty (free to join)
- www.pathway.org.uk/standards
- The following is a link to a 30 minute talk on complex trauma and homelessness from a recent Faculty conference -
- https://vimeo.com/showcase/8268773/video/524006795
- To learn more, go to the Pathway online Inclusion Health Course https://www.pathway.org.uk/resources/learning-resources/online-inclusion-health-course/

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Keep Moving, Spread out, Make Friends
Learn, Share, Learn, Share, Learn, Share…..

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Professor Aidan Halligan, 1957 - 2015

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2008: Aidan had a plan

Aidan had ambition.

He wanted to change the National Health Service.

How to change a system?

One million staff, £120,000,000,000 budget

Tactics:

- Do something,
  - We started in a hospital
- Generate evidence
- Share, collaborate
- Spread out, Keep moving

University College London Hospital

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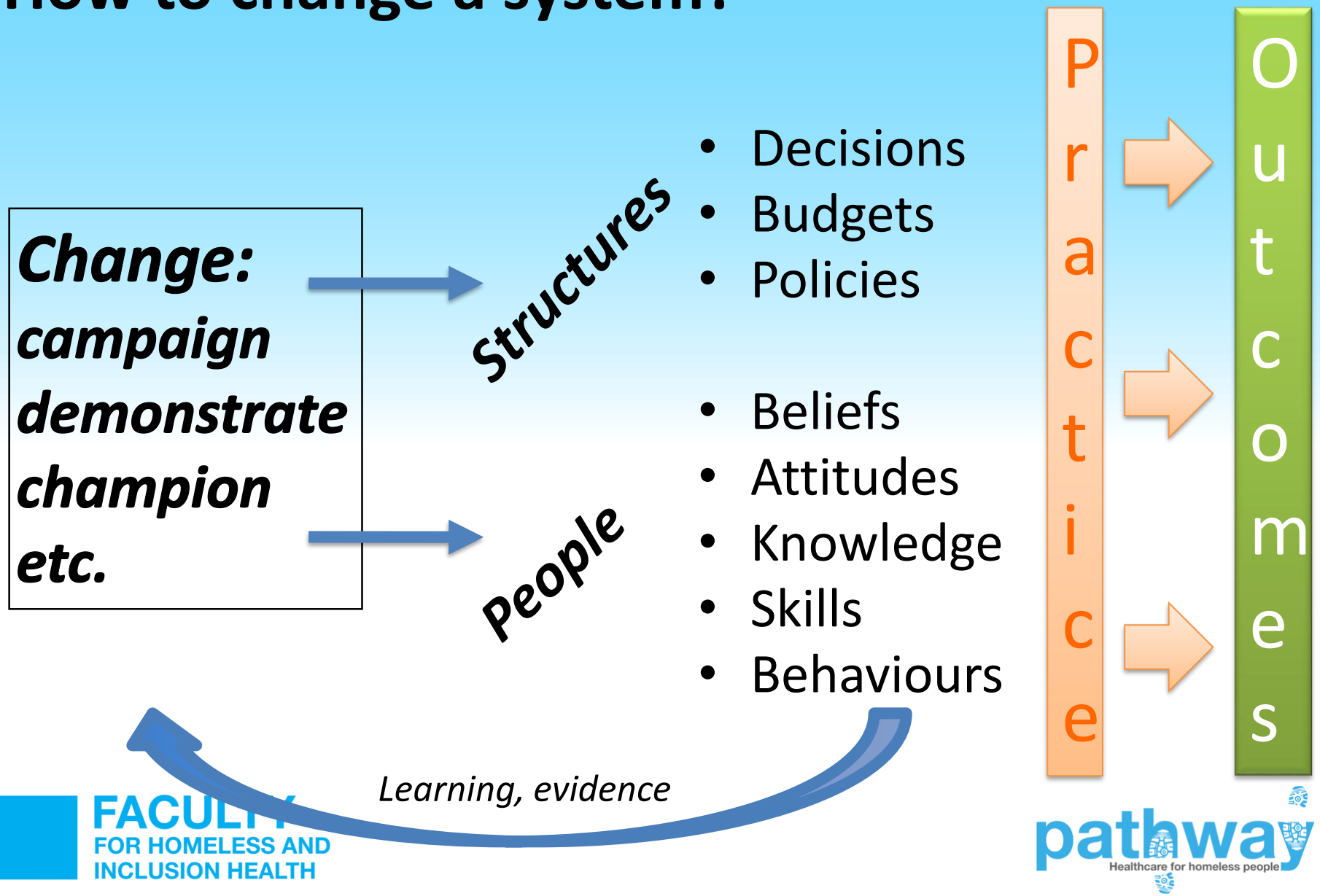
How to change a system?



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Mission

To transform the quality of healthcare experienced by rough sleepers and single homeless people across the UK, by developing and sharing the best models of compassionate care;

building on these models to improve health service provision for other multiply excluded groups;

and so improve health outcomes for the most marginalised in British society

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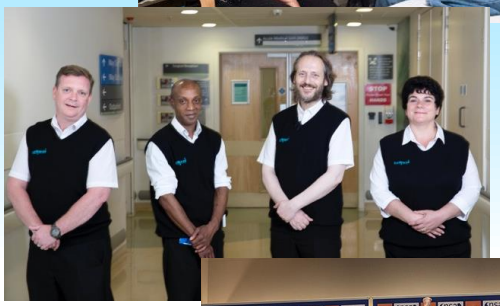
for equity and justice

- Independent charity: to transform health services and health outcomes for people experiencing homelessness
- Develop, test and implement new models of care for excluded people within the NHS
- Generate evidence, raise profile
- Training, education, conferences
- Involve people who have been homeless at every level
- Challenge, support, irritate, collaborate, shame, an agent of change
- Champion '*inclusion health*'



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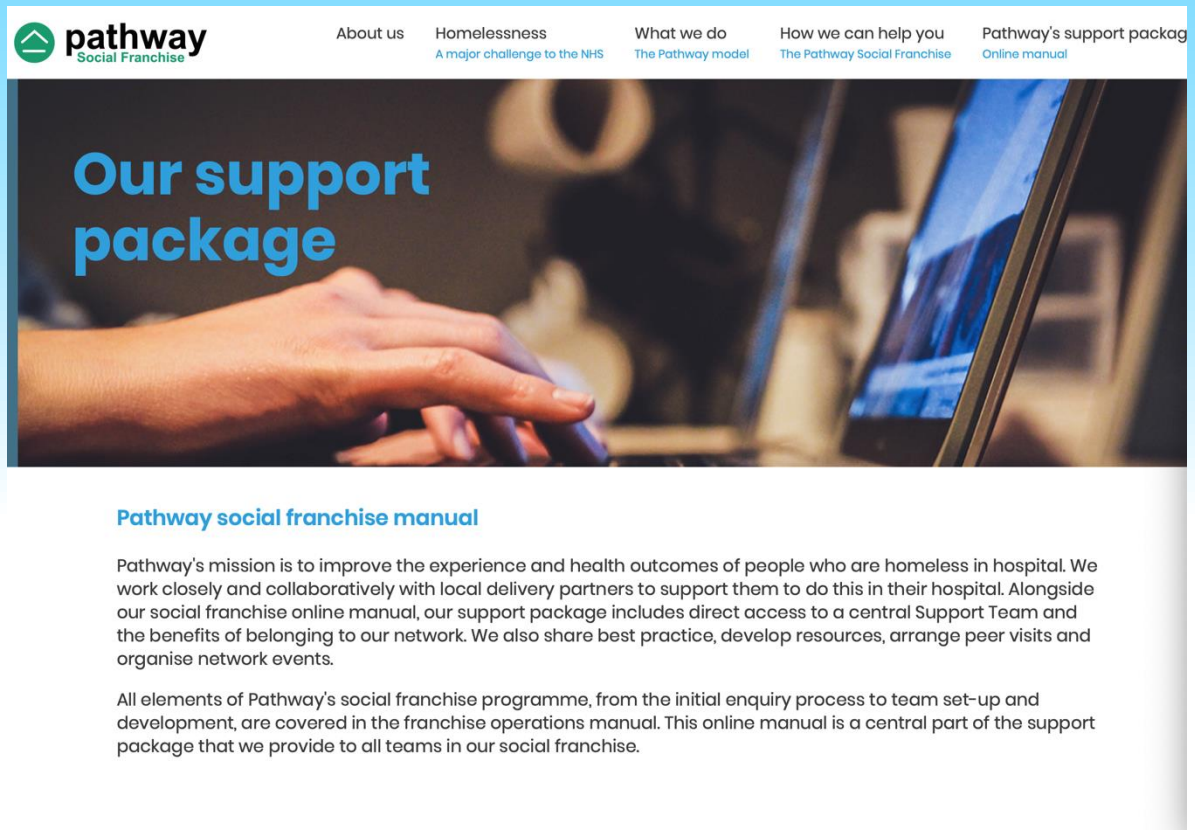
How to spread innovation in healthcare: a social franchise?

Objective:

Improve outcomes for homeless patients in hospital through:

- Confirmed best practice
- A clinical network
- shared standards
- team peer review
- quality improvement
- shared data standards
- mutual support
- National voice



https://www.pathwaysocialfranchise.org

Enhanced care co-ordination supported by a multi-disciplinary team

The Health Foundation

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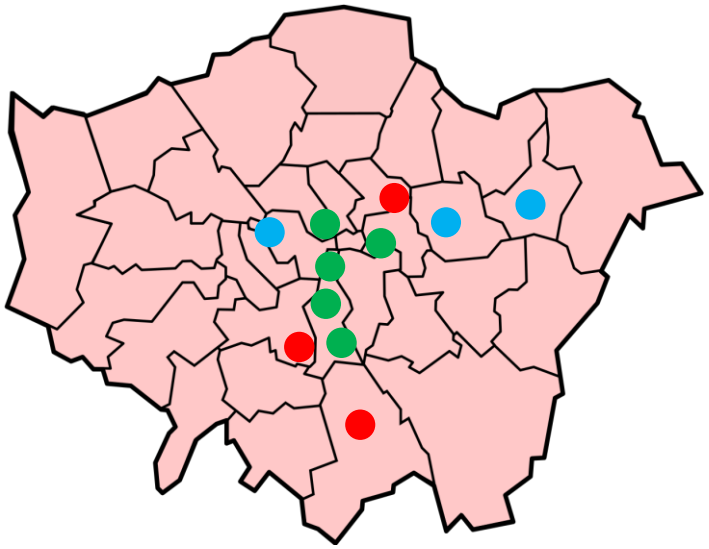
Royal Perth Hospital


NHS Parliamentary
NHS

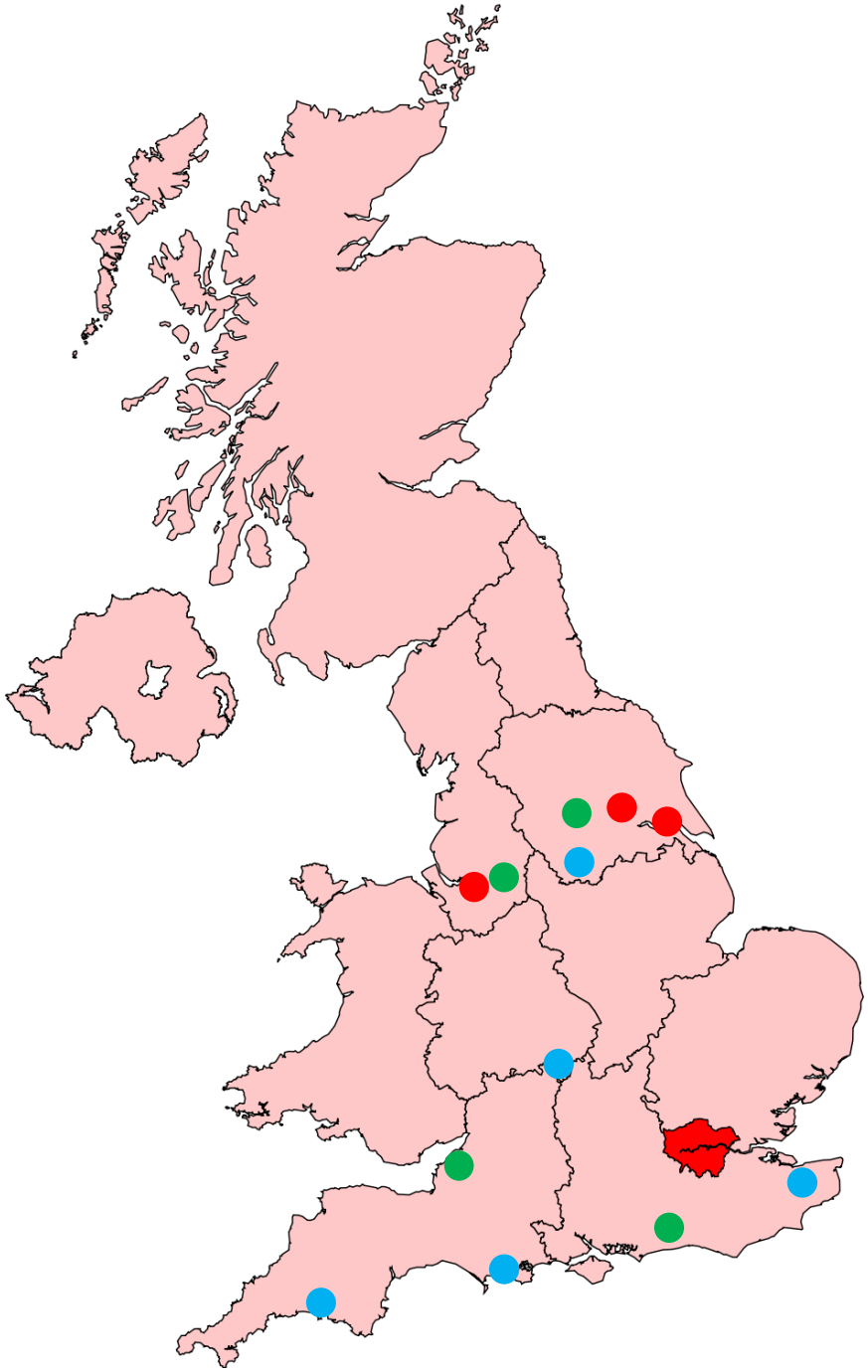

Health and Care
Innovation
EXPO 2016

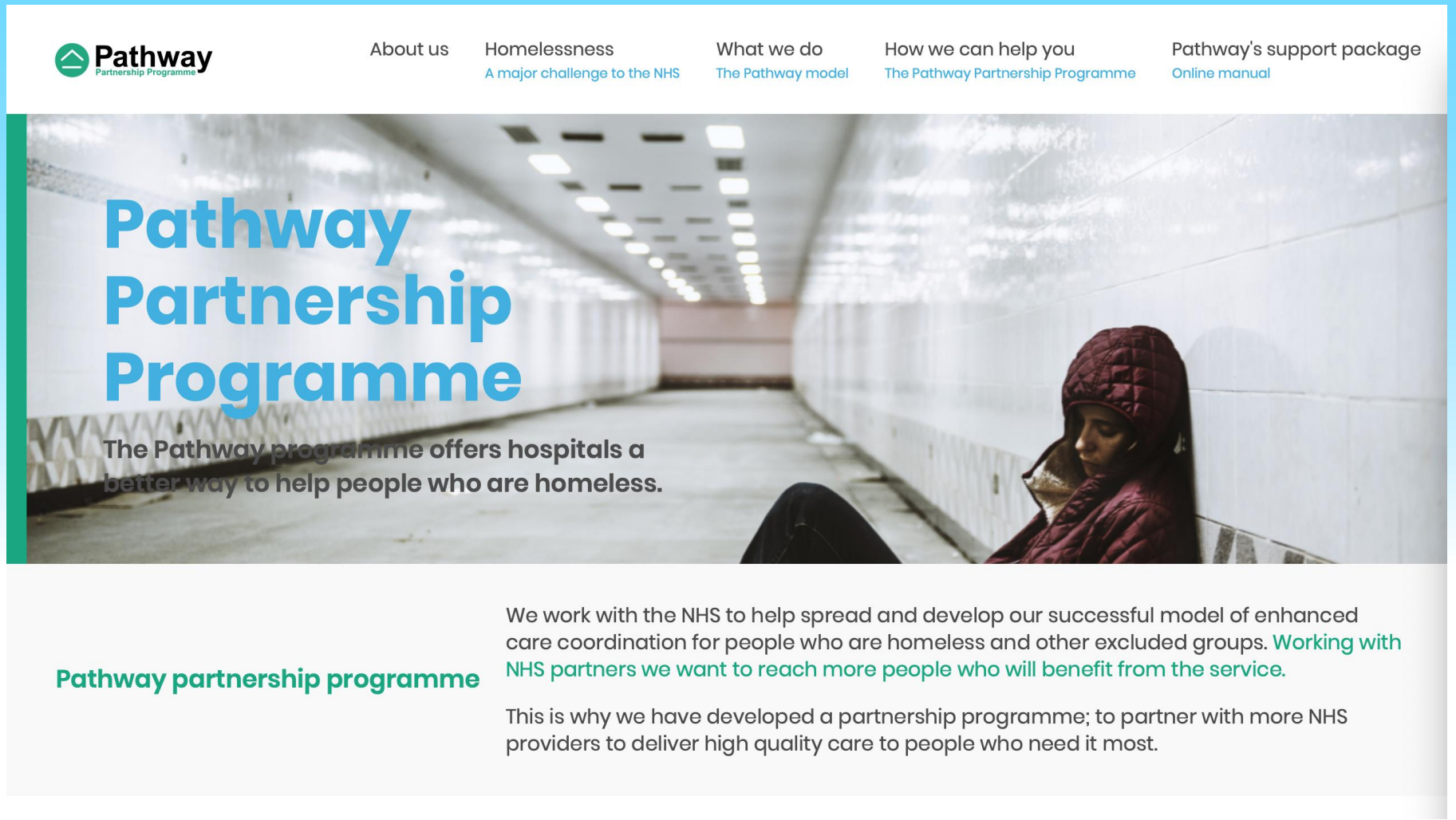
Pathway Teams – national map

- 9 Legacy Teams
- 6 Partnership Teams (including 1 converted Legacy Team)
- Needs Assessments ongoing, or possible future teams…



London





A growing national network

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Win endorsement: Royal College of Physicians endorsed standards

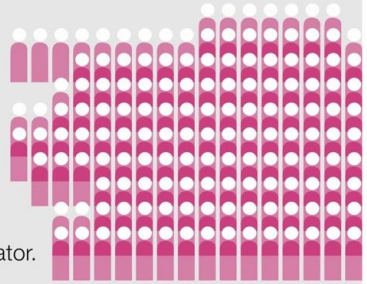
Does your hospital need a Pathway team? Hospitals seeing...

1-30 homeless patients each year need...

- an identified, responsible member of staff
- a referral protocol to the local authority, ensuring that all staff are aware of their duty to refer under the Homelessness Reduction Act
- an information pack with signposting to local hostels, food banks, housing department details
- a small supply of spare, warm, clean clothing.

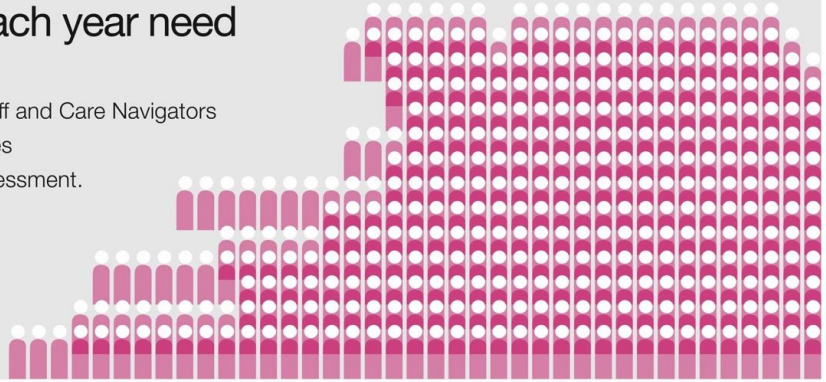
30-200 homeless patients each year need all the above, plus...

- a dedicated housing worker
- a named link hospital coordinator to maintain the referral protocol and support the housing worker in obtaining necessary medical assessments (with the patient's consent)
- strong relationships with the local council housing department, hostels and charities
- training and education of all hospital staff by the housing officer and named hospital coordinator.



200+ homeless patients each year need all the above, plus...

- a full Pathway team including GP, Nursing staff and Care Navigators
- a coordinator if the service spans multiple sites
- any specialist staff identified in the needs assessment.



Some Pathway Team quality metrics

- 80% of patients referred to the team are seen and assessed within 2 working days of receiving the first referral
- 85% inpatients receive a holistic assessment (in line with Pathway recommendations on assessment) which covers housing, primary care engagement, mental health, addictions and safeguarding and have a resulting care plan documented in their hospital notes as a result of the assessment.
- 100% of consenting homeless patients or patients at risk of homelessness seen and assessed by the team are referred to a Local Authority under the Duty to Refer as appropriate or are given equivalent appropriate advocacy or support to access housing – statutory duty
- Frequent attenders are identified, and plans are put in place to meet their needs
- Discharges that involve a return to rough sleeping are recorded (including self-discharges and abandonments), causes are identified, and appropriate interventions are delivered to reduce this happening
- Hospital staff are trained regarding a) the existence and purpose of the homeless team, b) the health needs of people experiencing homelessness and c) the duties of staff to people experiencing homelessness with reference to the Homelessness Reduction Act. Training contacts are recorded, and the effectiveness of this training is evaluated.

Quality

“You were the only ones that felt my life was worth saving - I am now back with the family I have not seen for 10 years”

“I’ve never stayed in hospital as long as this (2wks), I trust you, that’s why I am staying”

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[Strategic Objective Two]

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Making the case: for ‘Medical respite’

Olallo House

A place for:

- Continued convalescence and recovery with housing and health input
- Encouragement, empowerment, pastoral care, good food, safe space

Needs to be:

- Fully accessible
- Have access to substitute prescribing
- Have clear behaviour rules on site

NIHR study: 18% decrease in secondary care usage

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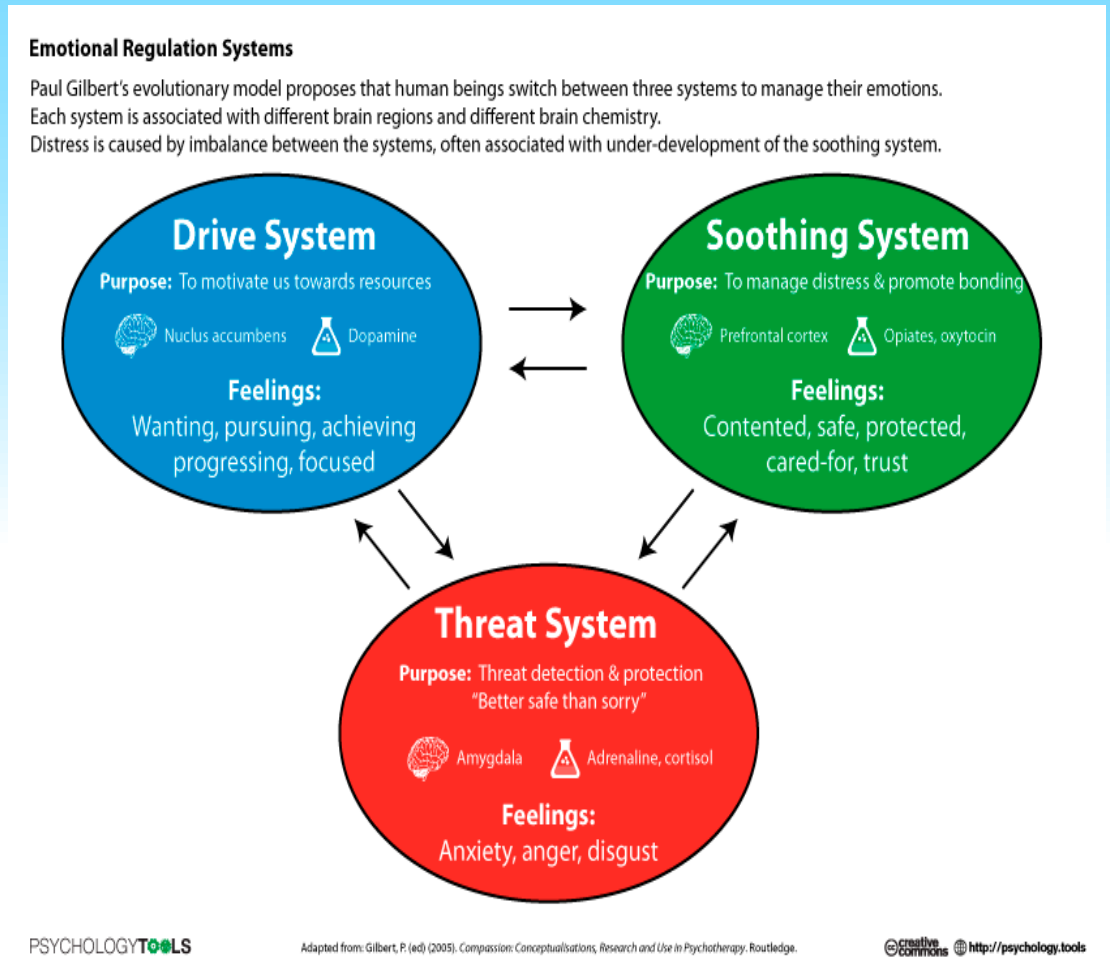
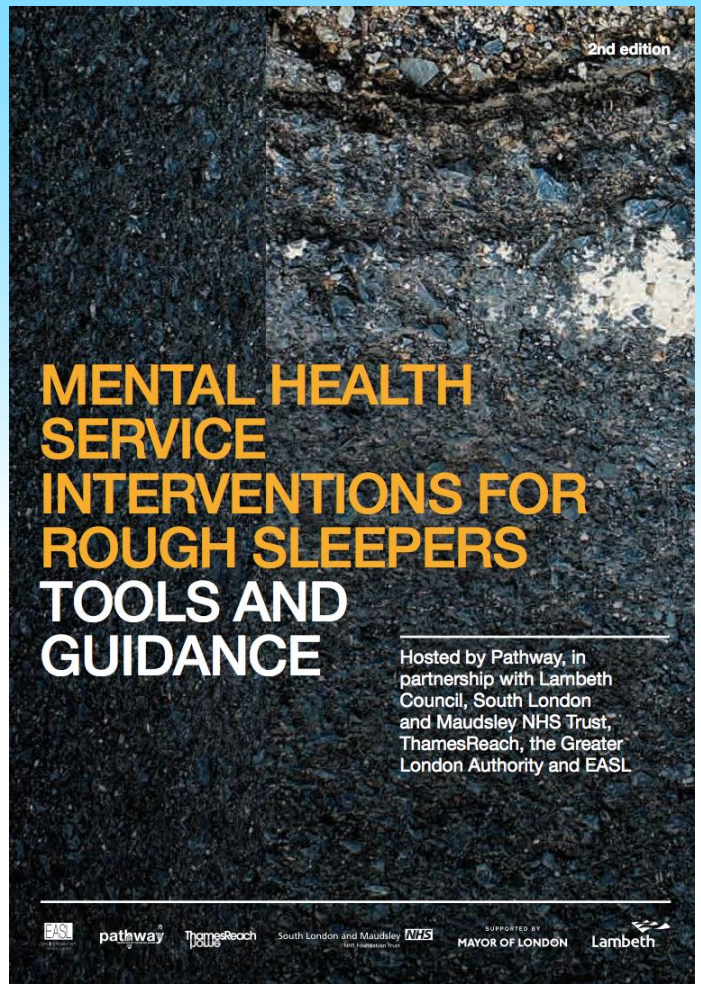
Best practice: the psychology of exclusion, trauma and mental health services





John Conolly, November 2018 jconolly@nhs.net

https://vimeo.com/channels/homelesshealth/325173923

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Best practice: End of Life Care and homelessness

Home > Services > Homelessness and Palliative Care

Homelessness and Palliative Care

- **Homelessness And Palliative Care**
- Acute Trusts
- Mental Health And Homelessness Guidance
- Primary Care
- Medical Respite Care

Support Us

Help us to help homeless people today

Homelessness and End of Life Care from Pathway and FHIH on Vimeo.

Homelessness and end of life care

People who are homeless often face severe health problems and early deaths – on average 30 years

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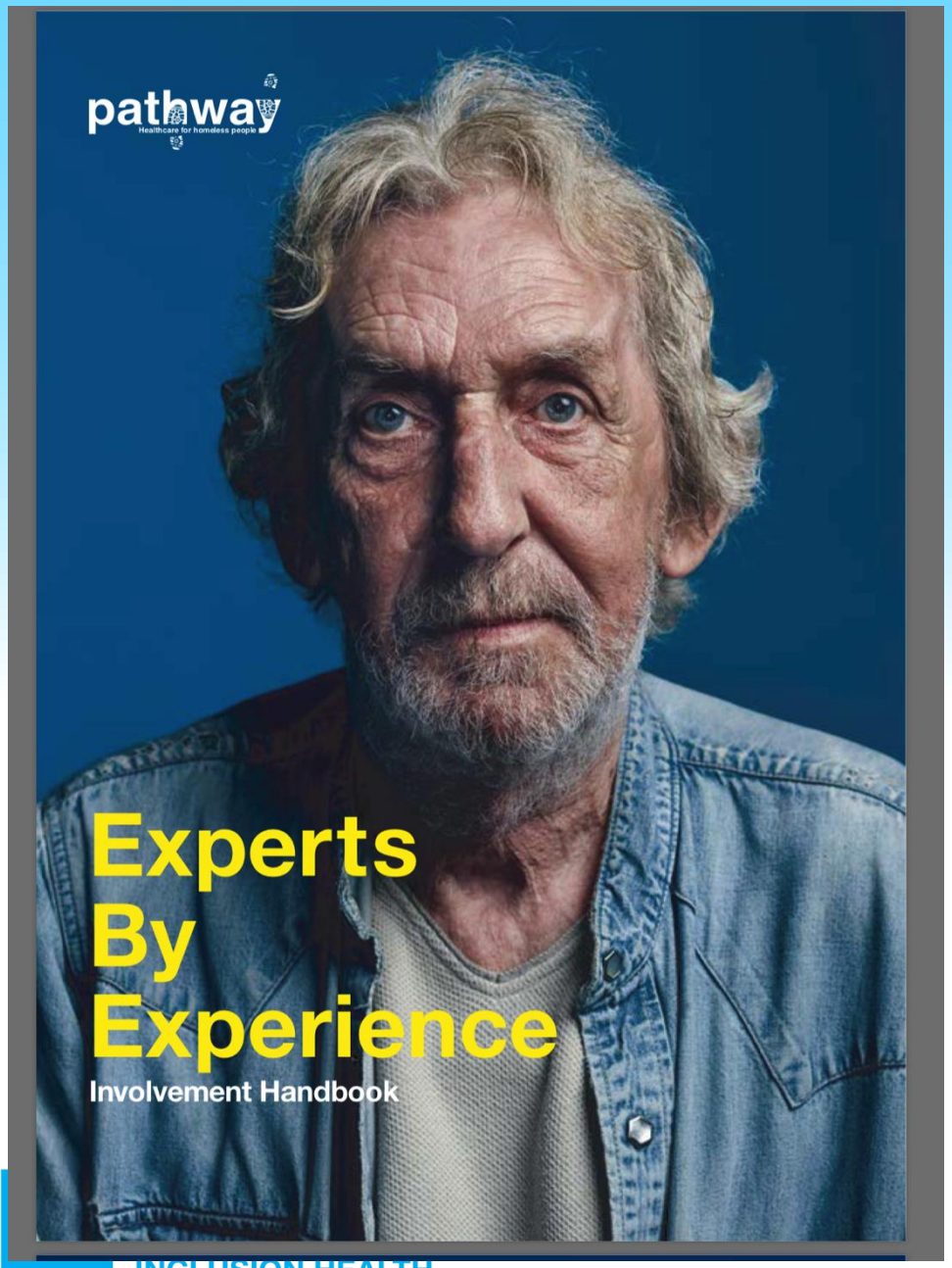

The power of lived experience

In research
In practice
In services
In campaigning

But:

Exclusion hurts
Trauma hurts
Stigma hurts

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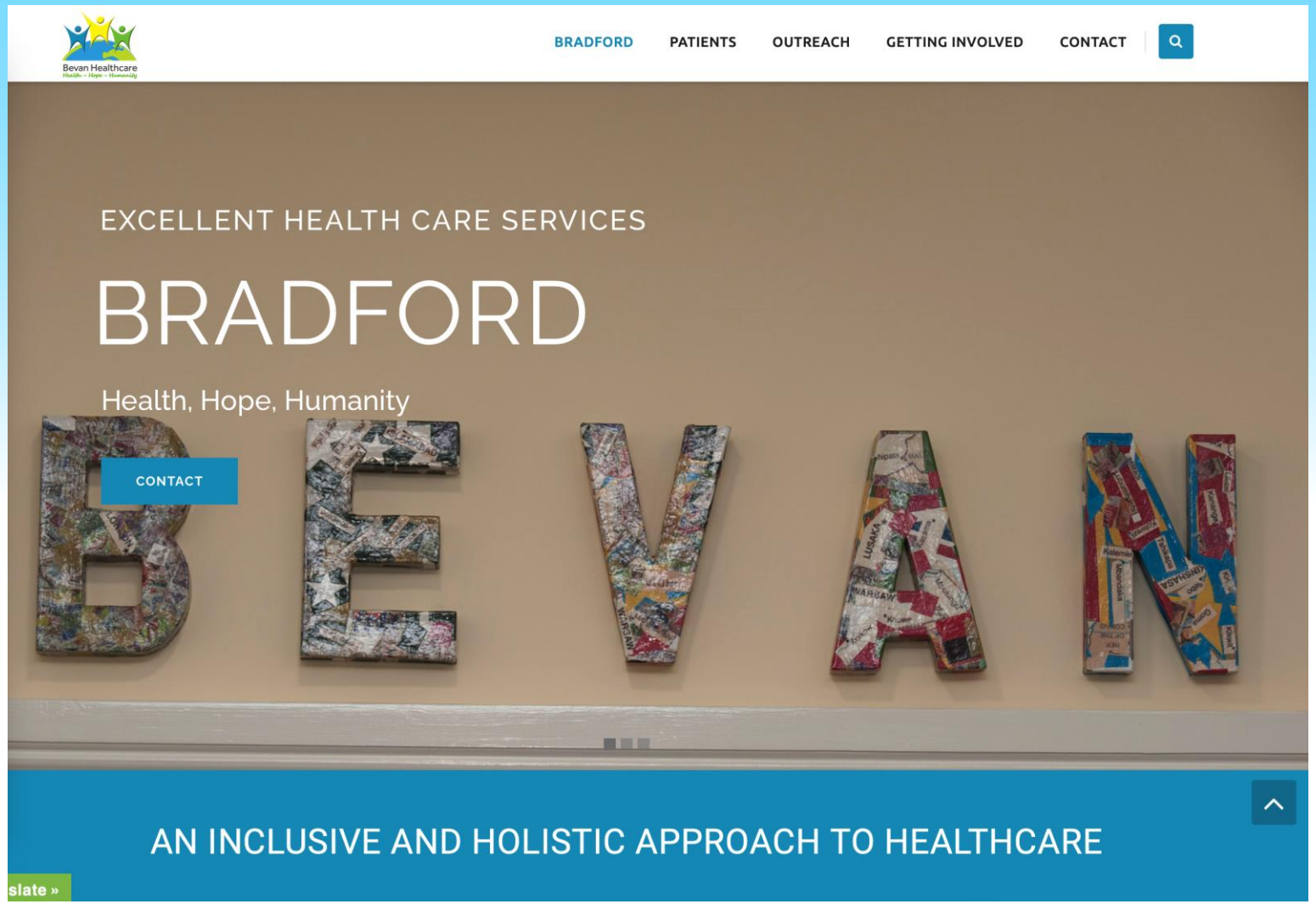
Great primary care for the most excluded



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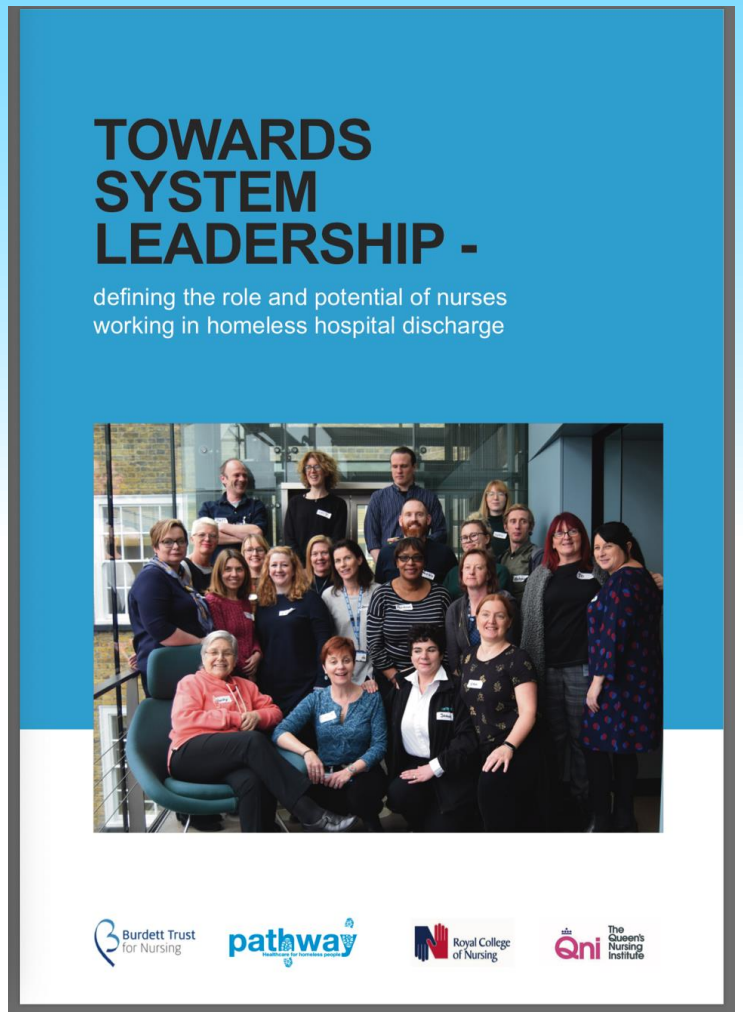
Making the case



FACULTY FOR HOMELESS AND INCLUSION HEALTH

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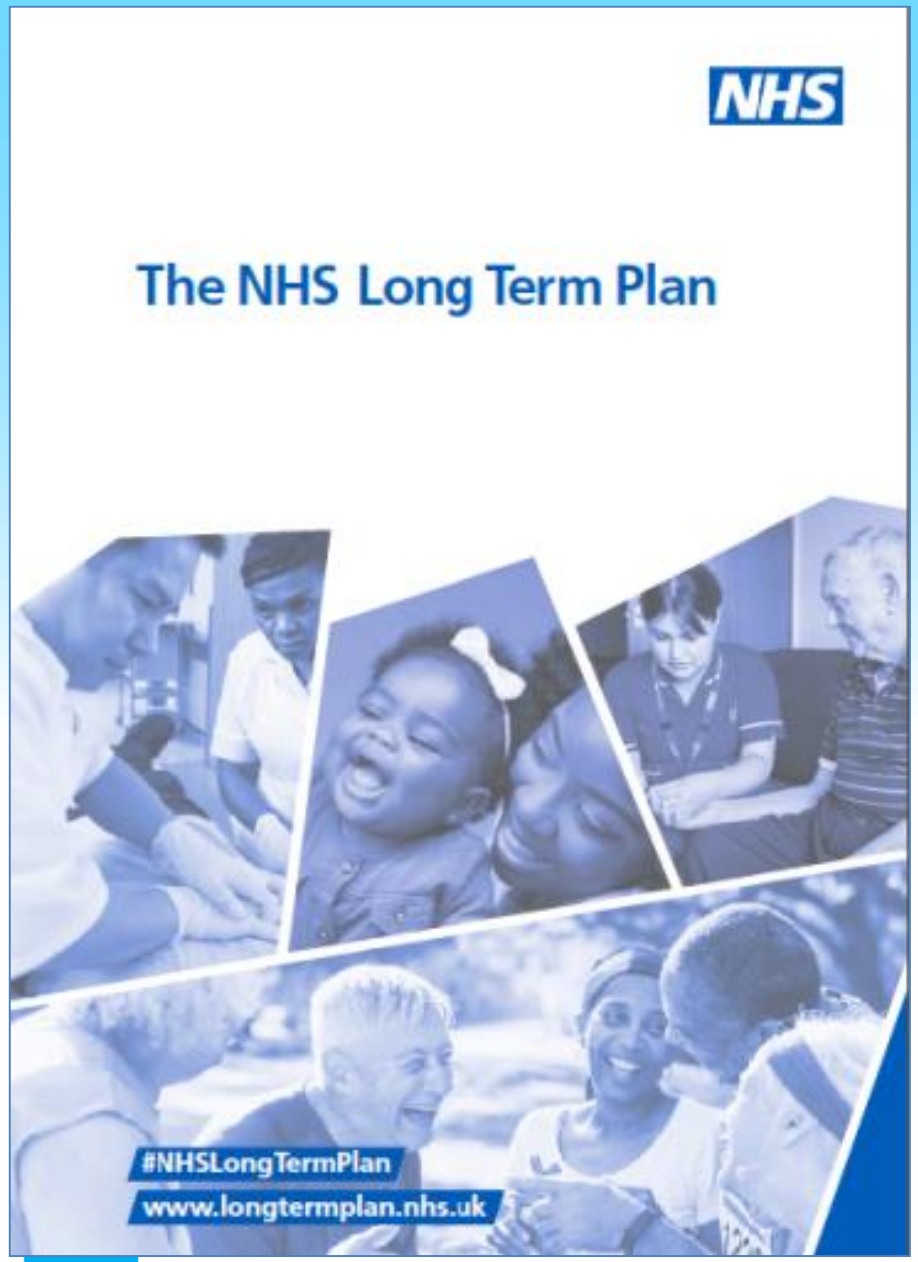

FOR HOMELESS AND INCLUSION HEALTH

System change?

Inclusion health in the plan

£30 million for mental health services for rough sleepers

Pathway cited as best practice

Bevan Healthcare celebrated

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Conclusions: what should the NHS do?

- ✓ Specialist primary care
- ✓ Mobile, outreached services (Find and Treat)
- ✓ Pathway hospital teams – linking it up
- ✓ specialist intermediate care
- ✓ Multi-disciplinary, inter-professional working is essential
- ✓ Psychologically/trauma informed practice
- ✓ Trusting relationships underpin good care
- ✓ Access, access, access
- ✓ Low/no threshold services
- ✓ Health services are only part of solution
- ✓ Housing, social care, support,
- ✓ **Inclusion Health**

THE STATE OF CARE IN THE FUTURE COULD LOOK LIKE THIS - MANAGED CLINICAL NETWORKS OF SPECIALIST HOMELESS SERVICES BASED ON PATHWAY'S EVIDENCE BASE, VALUES AND STANDARDS.

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https://www.pathway.org.uk/wp-content/uploads/Pathway-10-year-review-FINAL-PAGES.pdf

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Resources slide

- www.pathway.org.uk/faculty (free to join)
- www.pathway.org.uk/standards
- The following is a link to a 30 minute talk on complex trauma and homelessness from a recent Faculty conference -
- https://vimeo.com/showcase/8268773/video/524006795
- To learn more, go to the Pathway online Inclusion Health Course https://www.pathway.org.uk/resources/learning-resources/online-inclusion-health-course/

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