Lucy Harrison and Jenny Schaefer. March 2019

NEW HOSPITAL HOMELESS SUPPORT TEAM SAVES THE NHS

£766000

SUMMARY OF DISCUSSION

-Identifying and proving the need for a service.

-The team: who are we and what did we do?

-Outcomes.

IDENTIFYING THE NEED FOR A HOMELESS SUPPORT TEAM

The basic facts

-The average age of death for a homeless woman is 43, and 47 for a man. (crisis.org.uk)

-Homelessness is identified as a healthcare problem. (Pathways)

-People experiencing homelessness are 6 times more likely to present to hospital, and 4 times more likely to be admitted than someone who is housed. (Queens Nursing Institute)

-People who are homeless live with serious health conditions, which are often only treated when they have developed to a significant or serious state. These are usually accompanied by a range of other health problems. (St Mungos)

-People experiencing homelessness tend to report poor experiences and outcomes at hospital discharge. People experiencing homelessness also have a much higher rate of self discharge than the rest of the population . (Queens Nursing Institute)

-Homeless people are 40 times more likely not to be registered with a GP, and are highly likely to have untreated conditions. Emergency departments are often used instead of primary care. (Queens Nursing Institute)

Why fund in Bristol

-Various teams working with individuals experiencing homelessness in hospital and in the wider community were becoming increasingly concerned by the large numbers of clients they were seeing and the lack of support available.

-Following a visit from the pathways team in 2016, it was identified that their model of work would benefit those experiencing homelessness who come into the Bristol Royal Infirmary.

-To understand our local population needs, a Bristol GP performed an initial audit. This showed the potential for reducing re-admission and re-attendance rates for those who are classed as homeless or vulnerably housed, following the pathways model. This was then presented to the CCG, and funding for an 18 month pilot was approved. Over 18 months the pilot cost was £180,000 in salaries for the staff and initial I.T setup.

-The service was funded for adult patients (18 or over) who are homeless and/or vulnerably housed and who are:

An inpatient at the Bristol Royal Infirmary

Identified as a frequent attender at Bristol Royal Infirmary A&E

THE TEAM- WHO ARE WE?

NHS Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

COMMISSIONER

St Mungo's Ending homelessness Rebuilding lives

OUTREACH WORKER
30 hrs per week

BrisDoc Patient care by people who care

GP
4hrs per week

University Hospitals Bristol NHS NHS Foundation Trust

REGISTERED NURSE/ TEAM COORDINATOR
37.5 hrs per week

BRISTOL CITY COUNCIL

SOCIAL WORK PRACTITIONER
18.75 hrs per week

WHAT WE DO

The model of work

-Housing and benefits advice.

-Help to recover important documents such as birth certificates, passports etc.

-Links to community services.

-Support and collaboration with other clinicians e.g. advice on drug interactions, addictions, personality issues etc.

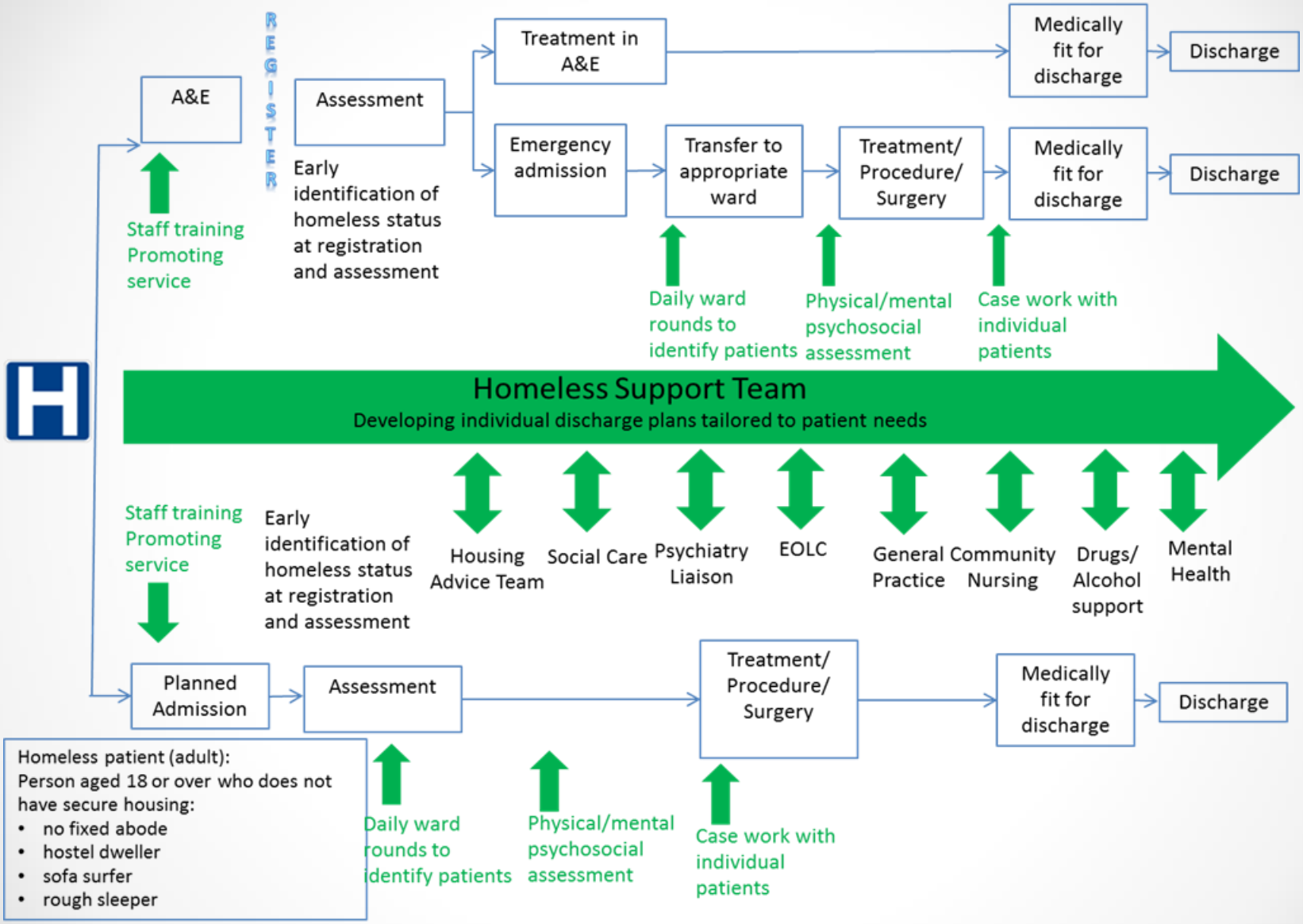
-Complex care planning and discharge liaison.

-Referral for addictions support.

-Help with GP registration.

-Fresh clothes, shoes and other basics (for example where these have been destroyed because of infection/infestation).

-Help to reconnect with loved ones.


A&E
REGISTER
Assessment
Early identification of homeless status at registration and assessment
Staff training Promoting service
Treatment in A&E
Emergency admission
Transfer to appropriate ward
Treatment/ Procedure/ Surgery
Medically fit for discharge
Discharge
Medically fit for discharge
Discharge
Daily ward rounds to identify patients
Physical/mental psychosocial assessment
Case work with individual patients
Homeless Support Team
Developing individual discharge plans tailored to patient needs
Staff training Promoting service
Early identification of homeless status at registration and assessment
Housing Advice Team
Social Care
Psychiatry Liaison
EOLC
General Practice
Community Nursing
Drugs/ Alcohol support
Mental Health
Planned Admission
Assessment
Treatment/ Procedure/ Surgery
Medically fit for discharge
Discharge
Homeless patient (adult):
Person aged 18 or over who does not have secure housing:
• no fixed abode
• hostel dweller
• sofa surfer
• rough sleeper
Daily ward rounds to identify patients
Physical/mental psychosocial assessment
Case work with individual patients

Aims and objectives/ KPI's

Performance standards

-Reduce rates of admission and re-admission (within 28 days).

-Reduce attendance and re-attendance in A&E (within 28 days).

-Increase the number of homeless A&E frequent attenders with a care plan.

-Reduce number of patients discharged with no housing provision in place.

Quality standards

-Improve health outcomes for homeless patients.

-Improve the experience of hospital discharge for homeless patients.

-Improve quantity/quality of information available on discharge.

-Increase engagement with primary care (e.g. increase GP registrations).

-To understand the overall level of satisfaction the patients have of the service provided by The Homeless Support Team.

-To understand the overall level of satisfaction the healthcare professionals have of the service provided.

-To identify what works well and any opportunities to further improve the service provided.

OUTCOMES

Reducing length of stay, re-admission rate and self discharges

In-patient stays

UHB Admissions for NFA (No Fixed Abode) or Hostel	Initial Audit April 2014-2015	With HST January 2017-2018	% change
Number admitted	238	180	↓ -24.3
Average Length of Stay	11 days	2.8 days	↓ -74.5
Number self-discharged	28	18	↓ -35.7
Number re-admitted within 28 days	132	50	↓ -62

Emergency Department

UHB A&E Attendances for NFA (No Fixed Abode) or Hostel	Initial Audit April 2014-2015	With HST January 2017-2018	% change
Total number of A&E Attendances	324	252	↓ -22
Number re-attended within 28 days	152	78	↓48.7
Number self-discharged	Not known	62	N/A
Number admitted	238	180	↓ -24.3

Reducing number of patients returning to the streets on discharge

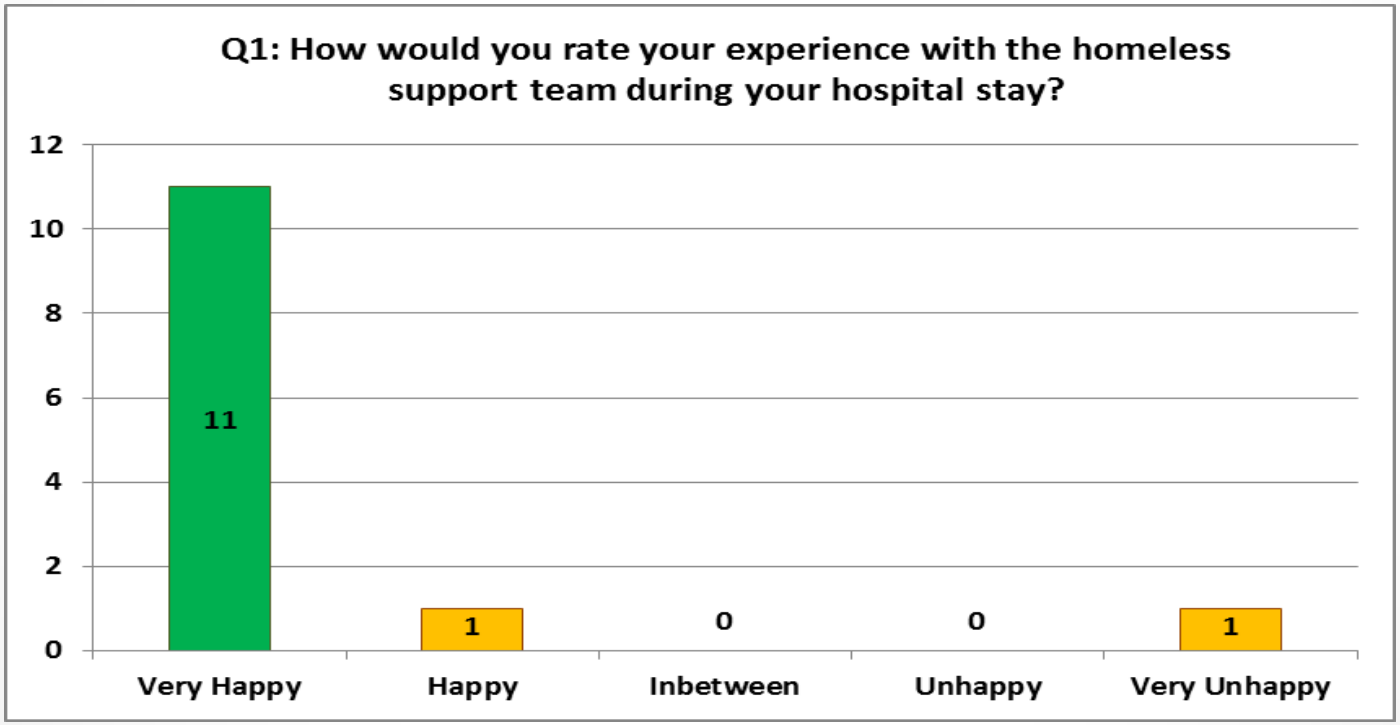
Housing on Admission	Number	%	Housing on discharge	Number	%
Evicted	2	1	Care Home	6	3
Hostel	29	17	Hostel	12	7
Housed	28	16	Family / friend	6	3
Rough sleeping	93	53	Rough Sleeping	6	3
Sofa surfing	11	6	Crash pad	9	5
			Reconnec-tion	7	4
			Returned to original housing	105	60
			St Mungo's shelters	6	3
Unknown	1		Unknown	1	1
Other	11	6	Other	17	10

Improving registration with appropriate GP

UHB Admissions for NFA (No Fixed Abode) or Hostel	Initial Audit April 2014-2015	With HST January 2017-2018	% change
Number admitted	238	180	↓ -24.3
Number registered with a GP	170	170	→
Number not registered with a GP	68	10	↓ -85.3
UHB A&E Attendances for NFA (No Fixed Abode) or Hostel	**Initial Audit April 2014-2015**	**With HST January 2017-2018**	**% change**
Total number of A&E Attendances	324	252	↓ -22
Number registered with a GP	207	231	↑ 10.3
Number not registered with a GP	117	21	↓ 82

Patient experience

All patients were given a paper feedback questionnaire to complete



Patient comments from filmed feedback

The main themes of the feedback were:

-The team provided reassurance.

-The team involvement meant a great deal to the patient.

-'Helped me so much'.

-Helped manage the 'pressure' of being homeless.

‘I am getting my wish to spend my time back with my family. Anything I do from now on I have the team to thank for. They have helped me so much’

‘The Homeless Support Team’ was a team I could confide in, talk to; they helped me recognise the people I need to contact in the Council, so I can make a housing application’

‘Some patients are very anxious about being discharged. Anxiety effects physical health’

‘The presence of the HST have highlighted the little knowledge staff have about supporting homeless people and their discharge from hospital’

Staff experience

‘HST support the patient and the staff to support discharge’

‘The support HST gives patients has an impact of their physical health, mood and emotional wellbeing’

Preventing premature discharge and inappropriate discharge

Outreach worker much more familiar with what is available than general discharge team / has access to the housing support register

Coordinating multidisciplinary meetings

Advocacy for patients

Following up transfers to other hospitals

ADDED VALUE OF THE TEAM

Team supports and works with other hospital specialist teams

Reduce anxiety of staff

Liaising with housing provider direct

Involvement in other hospital projects/ initiatives/ CQUINS

Liaising with and facilitating with our various community support services

Give opinions on homeless status and next step

Regular complex patients meetings with Homeless Health Service

Education of staff

We have now become a permanent hospital service!


702 referrals during
18 month pilot

Through reducing length of stay a financial saving of…

£766000

The future

-Ensure we continue to work in the suggested framework set out by the Homeless and Inclusion Health standards for commissioners and service providers (2018) to ensure a standardised approach to the care and support we provide.

-Looking at how we can be more integrated with Bristol's Homeless Health Service (primary care) and possibly to expand our current service to the other main city hospital.

-Auditing around specific issues we have come across to help inform further developments in our service.

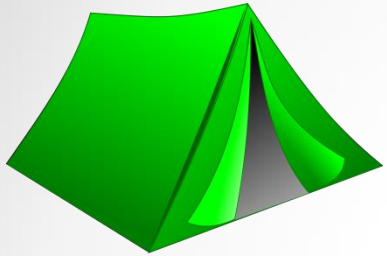
-Step down housing.

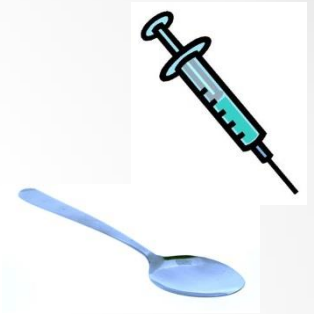
-Improving end of life planning and outcomes.

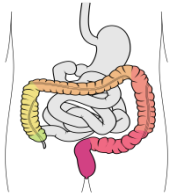
-Involving volunteers to support patients in hospital (especially those with lived experience).

-Developing a trust study day and to be included in staff trust inductions.

Case study -RK







ANY QUESTIONS