Impact on the use and cost of services following intervention by a Pathway Team in an acute mental health hospital

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Agenda

- Recent research paper 3 of 4 of SLaM Pathway Homelessness Team service evaluation
- Q and ? A
- NIHR GP in-Practice Fellowship
- “The experiences, role and use of IPE in Inclusion Health for healthcare staff, to improve quality of care for inclusion health groups.”
- Stakeholder engagement feedback

Background: Homelessness and Mental health

- Increasing homelessness – all forms
- Trimorbdity of Homelessness
- High prevalence of mental illness and dual diagnosis
- Few dedicated mental health services

Inclusion health

- Describes the healthcare needs of socially excluded groups
- Aims to prevent and redress the health harms of extreme inequity among the most vulnerable and excluded populations

The Challenge: designing and delivering services in mental health hospitals

- Patients may be admitted under and old addres
- Homelessness not routinely cod
- Pathway model
- ousing

3 years of pilot funding from GStT and Maudsley charities with an academic service evaluation

patients in a MH trust?

C whether the use of the KHP Pathway hom ess team had an impact on the use and cost of health and other services.

Setting: SLaM, KHP and South London

Pathway principals and values

- Advanced MHP – **role of the OT**
- Housing Worker – **NHS Funded from Voluntary Sector**
- GP – clinically led
- Business manager
- Senior clinical and operational management
- Academic support: Institute of Psychiatry and KCL

Service model

Aims: 1: optimise the admission 2: improve health, housing and wider outcomes for homeless people admitted to hospital and 3: improve quality of care while reducing delayed or premature discharges from hospital (Khan et al., 2018)

- Ward based audit: modify referral criteria
- NHS Spine, CHAIN, EMIS Web, Local linked care record
- Holistic assessments
- Close communication
- Cross sector collaborative working

Services we work with

Wards	Reablement Team (Southwark)	START Team	Southwark Law Centre	Bed management meetings	Local authority Housing Departments	St Mungos, The Passage, St Giles
GP surgeries	Street Outreach teams	Hostels	Place of Safety	Non-local authority housing providers	CMHTs	Health Inclusion Team (HIT)
No Recourse Teams	Hospital Social Work teams (Lambeth & Lewisham)	KHP Teams at Kings and GSTT	Routes Home	Night Shelters	Home Office / Immigration services / Embassies	Welfare teams – for benefits advice and support
Department of Work and Pensions	Police –Probation	OT department	Solicitors	Homeless Day centres	HIV Liaison Team	Other Mental Health Trusts

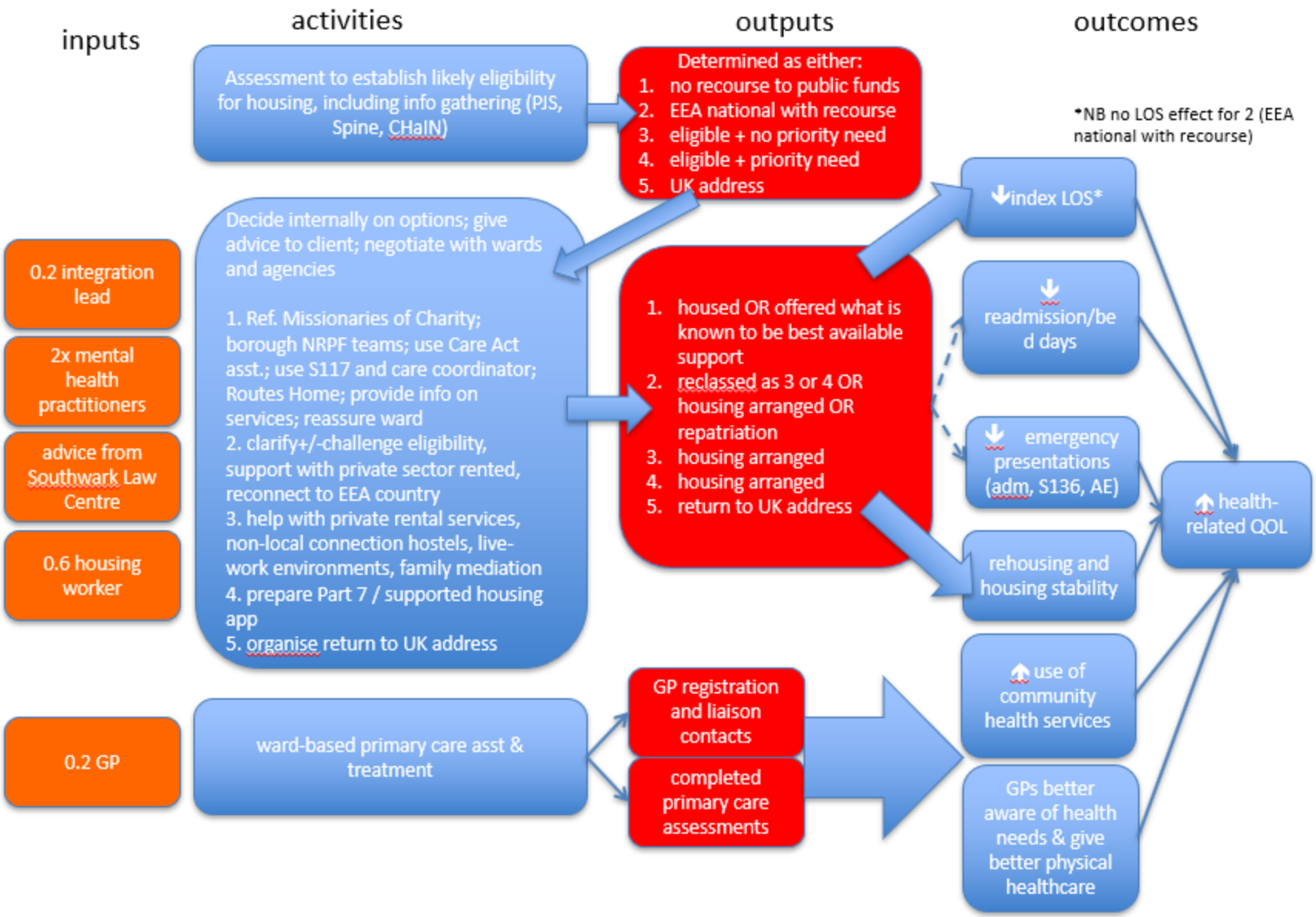
Wellbeing Hubs	Solidarity in a Crisis	Interpreter services	Food banks

Interventions

Methodology

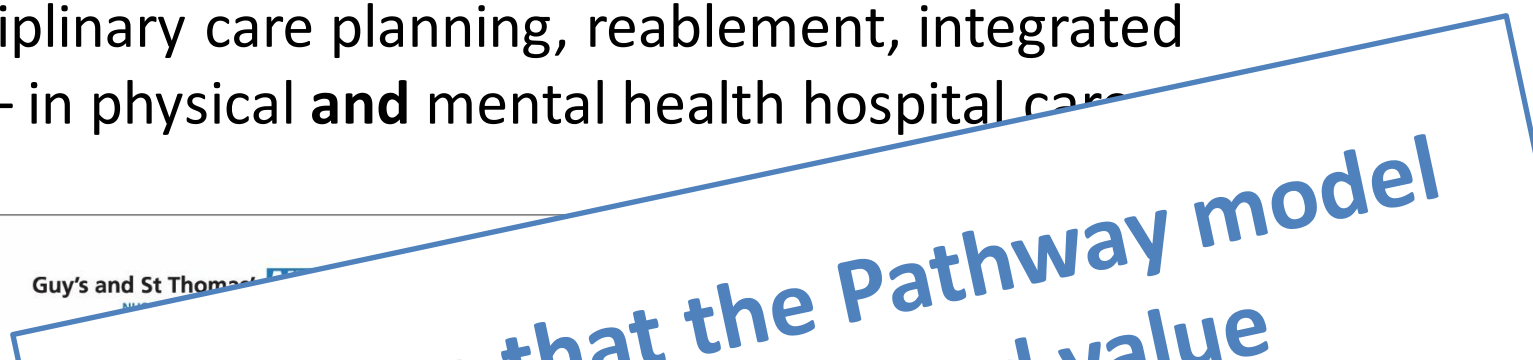
- Multiple scoping literature reviews
- Trial was not feasible
- Measur
- V ious three
  n
- Al data
- Additional data analysis and service narrative papers

Logic Modelling and Flexible use of the MRC Framework


inputs
activities
outputs
outcomes
Assessment to establish likely eligibility for housing, including info gathering (PJS, Spine, CHaIN)
Determined as either:
1. no recourse to public funds
2. EEA national with recourse
3. eligible + no priority need
4. eligible + priority need
5. UK address
*NB no LOS effect for 2 (EEA national with recourse)
0.2 integration lead
2x mental health practitioners
advice from Southwark Law Centre
0.6 housing worker
Decide internally on options; give advice to client; negotiate with wards and agencies
1. Ref. Missionaries of Charity; borough NRPF teams; use Care Act asst.; use S117 and care coordinator; Routes Home; provide info on services; reassure ward
2. clarify+/-challenge eligibility, support with private sector rented, reconnect to EEA country
3. help with private rental services, non-local connection hostels, live-work environments, family mediation
4. prepare Part 7 / supported housing app
5. organise return to UK address
1. housed OR offered what is known to be best available support
2. reclassed as 3 or 4 OR housing arranged OR repatriation
3. housing arranged
4. housing arranged
5. return to UK address
index LOS*
readmission/bed days
emergency presentations (adm, S136, AE)
rehousing and housing stability
health-related QOL
0.2 GP
ward-based primary care asst & treatment
GP registration and liaison contacts
completed primary care assessments
use of community health services
GPs better aware of health needs & give better physical healthcare

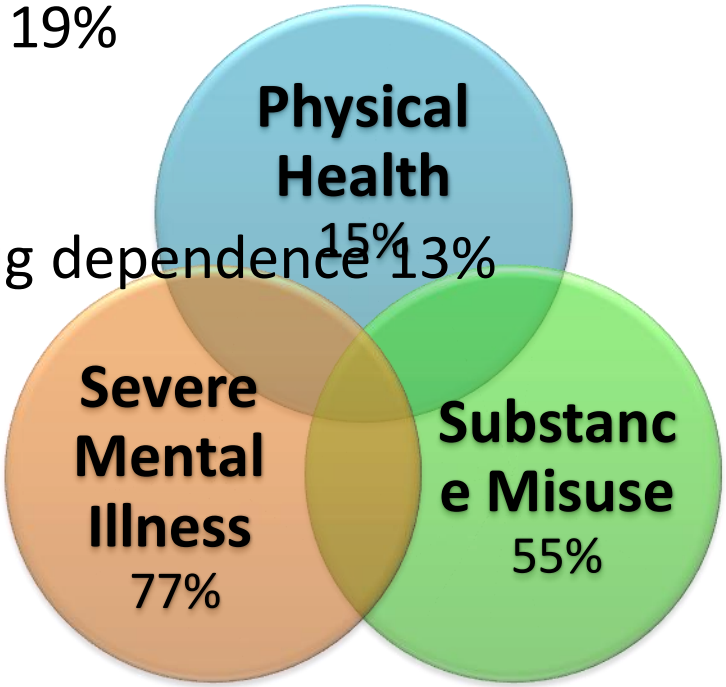
Scoping review

- Contacts are frequent and ineffective
- Perfect storm of austerity, welfare and public service cuts
- Dramatic increases in hospital attendance, admission
- Poor discharge arrangements, delayed discharge (SLaM)
- Considerable burden of mental illness
- Admissions are for Trimorbdity
- International evidence supports intensive support for people experiencing homelessness – inpatient psychiatric setting
- Multidisciplinary care planning, reablement, integrated working – in physical **and** mental health hospital care



Trimorbidity and Homelessness: add percentages and diagnosis

Severe mental illness 77%
Emotionally unstable personality disorder 19%
Suicidality and self harm 38%
Trimorbidity 25%
Alcohol misuse 24% Dependence 17% Drug dependence 13%
Chronic diseases 14%
High prevalence of hepatitis and HIV
1/3 under the age of 25



Adapting the CSRI

- Used in numerous health and social care evaluations
- Simple questionnaire exploring how often patients have had face to face contacts with a range of services
- Baseline and 3- and 6-month follow-up by phone
- Provide phones as routine

PJS Number: Date of Admission:

Date Completed: Patient Contact Number:

Please circle survey date`: Admission/ 3 month/ 6 month / 12 month

CLIENT SERVICE RECEIPT INVENTORY – HOMELESSNESS STUDY

1. In the last 3 months, what face-to-face contacts have you had with these professionals?

(Note: only record one-to-one contacts here; see next questions for group activities and inpatient care)

Care provider	*Have you had contact?* (circle)	*Usual location* 1 = GP 2 = Community centre 3 = Hospital OPD 4 = Own home 5= in patient	*No. of contacts in last 3 months*
A. General practitioner (GP)	*No Yes*		
B. Psychiatrist	*No Yes*		
C. Other doctor	*No Yes*		
D. Drug & alcohol advisor	*No Yes*		
E.- Home treatment / crisis team member	*No Yes*		
F. Social worker	*No Yes*		
G. Mental health nurse	*No Yes*		
H. Other professional	*No Yes*		

2. In the last 3 months, have you been admitted to hospital as an inpatient? *Yes* or *No* *(please circle)*

If yes:

Name of hospital and ward	*Reason for admission*	*Dates*		*Total days*
		Admission	*Discharge*	

3. In the last 3 months, how many times have you been to A&E? _____

THANK YOU FOR YOUR TIME

Exclusions and Data Handling

- Informed and signed consent
- Routinely provided with a basic phone and top up for follow-up care
- Patient's discharge address and phone number are recorded on patient record systems
- Calls were attempted 3 times, on different days and at different time
- Couldn't establish contact with a patient at 3 months, they called again at 6 months

Findings: demographics and outputs

- 237 of 465 were accepted and seen
- 74% improved housing status
- 11% had housing loss prevented
- 24% homelessness application
- 28% supported accommodation
- Most seen by housing worker
- 95 GP letters

- 24% NRPF
- Increase in reported rough sleeping from 24% to 48% in year 1 to 2
- 34% no local connection to SLaM
- 30% offered reconnection
- 21% accepted
- Support given to all

Results: 3 vs 6 months

61 patients FU

- A&E: 72% vs 17%
- Admission: 30% vs 9%
- GP: 48% vs 57%
- Psychiatrist 16% vs 35%
- Social worker 3% to 22%
- Nurse: 10% vs 26%
- Cost £818 vs £414

Service	Cost per contact or day (£)
GP	33
Psychiatrist	136
Other doctor	136
Drug/alcohol advisor	26
Home treatment team	43
Social worker	40
Mental health nurse	43
Inpatient care (per day)	373
Accident and emergency visit	138

Conclusions

- Pathway intervention changed use of healthcare services after discharge from hospital
- Increase in use of scheduled and primary care.
- The service overcomes barriers frequently experienced by people experiencing homelessness in accessing support and community healthcare
- Use of the CSRI as an adjunct to evaluating services that work with homeless or other socially excluded groups

Key points

- Pathway homelessness teams are effective at care co-ordination, improving a range of outcomes, care and support from hospital
- Services in are underpinned by equity, quality and parity of care
- Refocusing on quality of care and value to health care systems

- Khan Z, Koehne S, Haine P, Dorney-Smith S. Improving outcomes for homeless inpatients in mental health. Housing, Care Support [Internet]. 2018 Dec 5;HCS-07-2018-0016. Available from: https://www.emeraldinsight.com/doi/10.1108/HCS-07-2018-0016

Questions?

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Guy's and St. Thomas' and Maudsley Charities

King's Health Partners

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For more information, including fees and eligibility please contact **Eva Schaessens**
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