Hull Modality Homeless Health Team Annual Report

June 2022 – July 2023

I will never forget the help that I have received from this team.

Pathway
Homeless & Inclusion Health

modality
A Commitment to Care

Contents

Section 1 – Executive Summary

Overview

The Hull Modality Homeless Health Team was launched in 2019 to respond to the complex health and care needs of the city's homeless population. This is the second annual report produced as part of the team's membership of the Pathway Partnership Programme, and the first since the contract to provide the service was taken over by Modality in October 2021.

The team operates in close collaboration with key stakeholders, recognising the importance of a unified approach. Key partners include Pathway, Hull City Council – "Changing Futures" & Housing, ReNew / Change Grow Live (Local Drug and Alcohol service and rough sleeper initiative), Humber (Homeless Mental Health Team), City Health Care Partnership (Tissue Viability, Podiatry and The Quays medical practice), Rejuvadent (Dental Services) and the local Integrated Care Board (ICB). Through these partnerships they deliver a comprehensive trauma-informed healthcare approach tailored to individuals experiencing homelessness in Hull. This collective effort reflects our commitment to providing holistic and compassionate care to the most vulnerable members of our community.

The report details key outcomes achieved by the team, vital improvements to service delivery and collaborative working, challenges faced during the year, and future opportunities for improving the health of people experiencing homelessness in the Hull City area.

The team continues to deliver a high-quality, compassionate and patient-centred service for a group of extremely vulnerable people and has achieved life-saving outcomes in terms of both health and housing. With Pathway's support, the team has adopted a strong focus on quality improvement and has been successful in driving improvements both internally to the service and among external services and organisations.

Referrals

During the year (June 2022-July 2023), the team opened 618 new care episodes (the period for which a patient stays on the team's caseload) for 387 individual patients. Of these care episodes, 417 came via a direct referral from A&E, Inpatient Wards or Community Services, and a further 201 were identified by the team during community outreach.

Key Outcomes

Over the year, the team has achieved multiple impressive outcomes:

- **Improving health and wellbeing –** the team recorded an improvement in health and wellbeing in 96% of all care episodes that were closed during the year (345/361).
- **Improving housing outcomes –** conducting clinically-led housing advocacy where appropriate, the team achieved a 52% reduction in rough sleeping and a 46% increase in hostel placements.
- **Ensuring appropriate community referrals –** of individual patients seen by the team, 90% were referred to mental health services, 53% to substance misuse services and 73% to other community services.
- **Working effectively to meet quality targets –** holistic assessments were completed in 100% of new care episodes and co-produced care plans were produced in 96% of care episodes. Additionally, 98% of all referrals were assessed within 2 working days of referral, ensuring timely access to specialist care.
- **Improving access to primary care –** the team registered 25 previously unregistered patients with a GP, ensuring continuity of care following hospital discharge. Additionally, the team re-engaged many more patients with their existing GPs.

Service Improvements

The team has shown an impressive commitment to driving improvement both within their service, and across the Hull City region. Key examples include, but are not limited to:

- **Improving access to dental care, liver scans, podiatry and tissue viability services** by working with local health services, charities and healthcare staff.
- **Supporting people experiencing sexual exploitation** by working with a local charity, Lighthouse. One of the team's nurses has provided 15 hours per week of support for Lighthouse clients.
- **Improving nutrition** by building nutritional assessments into the team's holistic assessment process and delivering relevant interventions.
- **Improving attitudes towards people experiencing homelessness** by delivering educational sessions at Executive Nurse meetings, conferences, and university lectures.

Awards and Achievements

The team's fantastic work has been recognised through:

- Being shortlisted for two *Nursing Times* Awards: "Team of the Year" and the "Dame Elizabeth Anionwu Award for Inclusivity in Nursing and Midwifery".
- The Clinical Nurse Manager was awarded the Queen's Nurse award.
- The team's Healthcare Assistant won the 'Chief Nursing Officers Award for Healthcare Assistants'.

Patient Feedback on the Service

"You are one of only a few people who have ever treated me like a human being."

"I feel heard, and not like a problem. You are on my side."

"I will never forget the help that I have received from this team."

Future Quality Improvement Opportunities

The team has employed a quality improvement approach to identify the following areas for future service development:

- Reducing self-discharge rates amongst admitted inpatients.
- Improving data collection processes to further evidence the impact of the service.
- Securing funding to expand the community element of the service, to provide more preventative healthcare.
- Employing a registrar to conduct clinical audits to identify further improvement areas.
- Expanding education and training offers around homeless health, to foster cultures of empathy and non-judgemental care.

Section 2 – Service Overview

2.1 Local Context

As a city, Hull faces high levels of deprivation. Leading homelessness charity Shelter estimated that on any given night in Hull in 2022, 397 were 'homeless', with the majority of these staying in Temporary Accommodation. In 2021/22, a total of 3,530 individuals were assessed as being owed a prevention or relief duty from Kingston upon Hull Council. This data was unavailable for 2022/23, but it is expected that the figure would be higher. Hull also has high rates of chronic obstructive pulmonary disease and multi-morbidity, especially amongst the local population of people experiencing homelessness. The Modality Homeless Health Team was

commissioned in late 2019 to provide health and social support for the city's homeless population. The contract was taken over by Modality in October 2021.

2.2 Inclusion Criteria

The team works with patients admitted to hospital or attending A&E who are identified as experiencing or at risk of homelessness.

Patients are referred to the team from A&E, hospital wards or community settings. The team also conducts community outreach work opportunistically, to identify individuals who need support, and to provide health support which prevents emergency attendances or admissions to hospital.

Patients accepted onto the team's caseload typically display complex combinations of needs, including physical health, mental health, substance misuse, safeguarding, and housing needs. They include individuals from a range of demographic backgrounds, people with No Recourse to Public Funds, and those with uncertain immigration status. A holistic approach is employed that considers the multiple challenges faced by people experiencing homelessness within the city and enables the team to respond appropriately and effectively.

2.3 Team Structure

The Modality Homeless Health Team Hull has been at the forefront of addressing the healthcare needs of people experiencing homelessness in Hull. Comprising a diverse group of professionals, the team is committed to delivering high-quality, compassionate, and comprehensive healthcare services to those experiencing homelessness. The team is led by the clinical nurse manager Kirsty Balfour.

The team includes:

- **Clinical Nurse Manager - Kirsty Balfour -** *oversees the coordination and delivery of healthcare services for the local homeless population, drawing on a wealth of expertise to ensure the team operate efficiently and effectively.*
- **Nursing Team –***3 nurses (1x Lead Nurse, 1x Hospital Nurse, 1x Community nurse) who provide holistic healthcare services, including wound care, vaccinations, medical assessments, and appropriate referrals. Their compassion, holistic approach and expertise are invaluable in building trust with clients.*
- **Trainee Nursing Associate –** *this role is a vital addition to the team, bringing fresh perspectives and helping to foster professional growth that contributes to the team's overall mission.*
- **General Practitioner –** *the team has 2 GPs who bring a wealth of clinical expertise to the team, conducting medical evaluations, prescribing necessary treatments and ensuring effective continuity of care*.
- **Trainee GP Registrar –** *this rotational role enhances the team's clinical capabilities and helps the team stay up to date with the latest medical knowledge and practice.*
- **Care Navigator –** *serves as a guiding light for patients, helping them navigate the complexities of the healthcare system and access necessary resources. Instrumental in ensuring that no one falls through the cracks.*
- **Care Coordinator –** *manages the logistical aspects of patients' care, ensuring appointments are scheduled, follow-up care is provided promptly, and that service data is consistently and accurately recorded.*

2.4 Team Activities

The team works flexibly to provide holistic health and wellbeing assessments in both hospital and community settings. Both the hospital and community elements of the service work in a person-centred way, to facilitate individualised strength-based assessments. The team works closely with other relevant services to deliver holistic health and practical support and ensures continuity of care by supporting patients following hospital discharge. Examples of activities conducted by the team include:

- Conducting holistic assessments covering physical health, mental health, substance misuse, housing and social factors for each patient.
- Providing personalised, co-produced support plans to address unmet physical health, mental health and substance misuse needs.
- Working in partnership with a range of other services and providers to ensure personalised wrap-around support for patients.
- Offering clinical judgement and expertise on complex issues, particularly cases where tri-morbidity (physical ill health, mental ill health and substance misuse) is present.
- Liaising between primary and secondary care to facilitate patients' access to primary care and supporting individuals with booking and attending various health and social appointments.
- Providing support to complete documentation around GP registration, benefits applications, housing applications and opening bank accounts.
- Working with legal providers to help patients with uncertain immigration status establish their immigration status and understand their legal entitlements to support.
- Providing housing advocacy where relevant, such as statutory referrals under the Duty to Refer, or liaising with third sector housing providers. Advocating for patients' legal rights for housing support.
- Conducting community outreach to support patients and to identify individuals who may need the support of the team.

2.5 Partner Organisations and Joint Working

The team works with a large number of organisations across the Hull City region, to ensure that patients have their needs effectively met. Some of the key organisations that the team works with are:

- RENEW – *local drug and alcohol service*
- Rough Sleeper Initiative (RSI) and Change Grow Live (CGL) – *outreach services*
- Changing Futures – Hull City Council
- Lighthouse – *charity supporting women affected by sexual exploitation*
- City Health Care Partnership (CHCP) – *not-for-profit health care provider*
- Hull University Teaching Hospitals (HUTH)
- Police, HMP Hull and Probation Services
- Safeguarding teams at the Council, CHCP and HUTH

- Local third sector housing providers
- Hull City Council housing options team
- MEAM – Making Every Adult Matter

2.6 Quality Improvement and Pathway Partnership Programme

This report marks the successful completion of four years of collaborative working between the Hull Homeless Health team and the Pathway charity, through the Pathway Partnership Programme. As part of this collaboration, the Hull Homeless Health Team employs a Quality Improvement approach to its work. The term 'quality improvement' refers to *"the systematic use of methods and tools to try to continuously improve quality of care and outcomes for patients."*

The team conducts Quality Improvement work by:

- Working within Pathway's Quality Framework (Appendix A) and using routine data to assess progress against key quality indicators.
- Collecting patient feedback – investigating and understanding the experience of patients who use the service helps the team to improve patient experience and engagement, and to generate better outcomes.
- Conducting audits - focussed audits are used to identify opportunities for improvement around care planning and assessment, self-discharges and discharges to the street.
- Creating reflective space within the team's work schedule to identify key challenges and opportunities.

As part of the programme, the Pathway charity has provided a range of support to the Hull Homeless Health team, including:

- Regular monthly support calls with the team to provide advice, guidance and support.
- Annual in-person visits, including attending the team's relaunch event and further review visits.
- Providing training for new and continuing team members around key topics such as housing.
- Supporting the team to engage in Quality Improvement processes through the Quality Framework, training and ongoing advice.
- Supporting the team to collect data that evidences service impact, conducting data analysis and producing reports and service evaluations to demonstrate the value of the service and assess quality performance.
- Connecting the team to a national network of Inclusion Health services and professionals, through All-Teams Meetings (nationwide meetings of Pathway teams) and places at Pathway's Annual 'Pathways from Homelessness' conference.
- Providing educational opportunities through Masterclass sessions, covering key topics such as Brain Injury, Immigration and No Recourse to Public Funds, Nutritional Assessments and Gender Based Violence.

- Securing specialist legal advice for the team, to provide advice and signposting for patients with No Recourse to Public Funds or uncertain immigration status.

Section 3 – Referrals, Outcomes and Quality Targets

Referrals and Outcomes

During the year, the team opened 618 new care episodes from 387 individual patients. Patients were either formally referred to the team (417 care episodes during the year), or opportunistically identified in A&E, Inpatient and Community settings for support (201 care episodes during the year). The team has generated impressive outcomes for these patients including:

Improving health and wellbeing

- The team recorded an improvement in health and wellbeing in 96% of all care episodes that were completed during the year (345/361).

Improving housing outcomes

- For hospital patients, the team conducted housing advocacy as appropriate, including referrals to statutory housing/third sector services, providing supporting medical evidence, accompanying patients to appointments and providing move-in support. Through this work, the team achieved a **52%** reduction in rough sleeping for inpatients (**46%** across all patients) and a **46%** increase in the number of hostel placements (all patients).
- The team also facilitated appropriate discharges to other care settings (**7%** of all inpatients), including rehab facilities, care homes, intermediate care and specialist mental health settings.

Ensuring appropriate community support

- **83%** of all hospital care episodes were transferred to the team's community follow-up support element following hospital discharge.
- Of the individual patients seen by the team, **90%** were referred to mental health services, **53%** to substance misuse services and **73%** to other community services.
- During the year, the team's most referred to community services were RENEW (271 patients referred), MHLT (107), Safeguarding (66) and MEAM (65).

Improving access to primary care

- During the year, the team has successfully registered **25** previously unconnected individuals with a GP, providing them with essential access to primary care services. This accomplishment reflects the team's dedication to addressing the unique healthcare needs of those experiencing homelessness and ensuring that they receive the medical attention they deserve.

- Furthermore, the team has worked tirelessly to re-engage many more patients with their GPs, reestablishing vital connections to ongoing healthcare. By bridging the gap between individuals experiencing homelessness and their healthcare providers, the team have enabled their clients to access critical medical services and follow-up care.

Quality Targets

The team has successfully met and exceeded key quality indicators as presented in Pathway's Quality Framework (Appendix 1).

Quality Target	Explanation	Outcome

80% of appropriate patients referred to the team are seen and assessed within 2 working days of first referral.	Assessing new referrals as quickly as possible ensures that patients have timely access to specialist care and allows more time for comprehensive care and discharge planning.	Of the 417 new care episodes that came from a direct referral, the team saw and assessed an impressive 98% within 2 working days.
85% of accepted referrals receive a holistic assessment which covers physical health, mental health, substance misuse, housing and safeguarding ***and*** *have a resulting care plan documented in their hospital notes.*	Conducting holistic assessments is a core activity of all Pathway Partnership teams, allowing patients' needs to be fully identified and effective plans put in place to meet these needs.	The team conducted an assessment in 100% of new care episodes, and co-produced support plans were documented in 96% of new care episodes.
80% of hospital patients have housing status recorded on both admission and discharge.	Effectively recording housing status is key to demonstrating the positive impact of the team's clinically-led housing advocacy.	The team recorded housing status on admission and discharge for 100% of all hospital care episodes, allowing them to demonstrate the impressive outcomes outlined above.
100% of self-discharges/abscondments are recorded, and interventions put in place to reduce self-discharge rates.	Self-discharges prevent patients from accessing the care and support they need and can be seen as a measure of hospital culture and quality of care. Self-discharge rates are therefore a key indicator of service quality.	The team recorded a discharge outcome (self-discharge Yes/No) for 100% of hospital care episodes. The identified rate of self-discharge from A&E (11.5%) was lower than typically seen at Pathway services, although the self-discharge rate for Inpatients (24.5%) was significantly higher. This has been identified as a key area for future service improvement.

Section 4 - Service Improvements

The team has showed an impressive commitment to driving improvement both within the service and through collaborative working relationships with other local services. Through their efforts and open communication, they have strengthened collaborations with local healthcare providers, social service agencies, and community groups. These partnerships have enhanced the effectiveness of the

holistic care provided by the team, and increased engagement has allowed the team to tap into valuable resources and support networks.

Internal Improvements

Improving nutrition – The team's GP is passionate about lifestyle medicine, with a particular focus on nutrition. She has worked hard to ensure that nutritional needs of patients are regularly determined and prioritised, by building adapted nutritional assessments into the team's holistic assessment process.

Improving data recording processes - The team has improved its data recording processes during the year, ensuring that all new care episodes and outcomes are accurately recorded. This has allowed the team to capture the extent of their work and provide evidence of the positive impact of the service more accurately.

Improvement through collaborative working

Improving access to dental care – the team has worked with Dentaid (a dental charity) to secure 2 days of free dental aid for people experiencing homelessness in Hull. Following the success of this collaboration, the team is also working with local ICB members to secure ongoing dental support for people experiencing homelessness. A local dental provider has been awarded a contract to provide emergency and long-term dental provision in the city.

Improving access to podiatry/tissue viability services – the team has collaborated with a local podiatry service to provide a once-a-month drop-in service for people experiencing homelessness, utilising the team's city centre base. Using the same approach, the team has managed to secure a trial for a drop-in tissue viability service.

Improving support for people experiencing sexual exploitation – the team has worked collaboratively with Lighthouse, a local charity that supports people facing sexual exploitation, to improve health provision for this group. One of the team's nurses has been seconded into Lighthouse to provide 15 hours of support per week for Lighthouse clients. This is an example of innovative collaboration to reach vulnerable cohorts of clients.

Improving access to liver scans and services – the team has worked collaboratively with secondary care liver consultants and specialist nurses to provide liver fibroscans for patients, along with any ongoing support and treatment that is subsequently required. Through "Changing Futures" the team has procured a portable couch which can be used for scans across various sites in the city, including hostels and "The Hub".

Education and Raising Awareness

Education and Training – the team has engaged in efforts to provide training and education around the health needs of people experiencing homelessness, in order to

foster cultures of empathetic and non-judgemental care. Examples include: presenting at Executive Nurse meetings within the Trust, presenting at the Queen's Nursing Institute Annual Conference, holding lectures at Birmingham University for post-graduate nurses, and presenting at NHSE events.

Raising Awareness – The team has actively worked to spread the word about the service and the critical issues facing patients, through regular communication with key stakeholders. These ongoing conversations have enabled the team to create a deeper understanding of the unique challenges faced by their clients and the necessity of the service.

Section 5 - Awards & Achievements

During the year the team has been recognised and commended for its impressive work, being shortlisted for two *Nursing Times* Awards: "Team of the Year" and the "Dame Elizabeth Anionwu Award for Inclusivity in Nursing and Midwifery".

The team's Clinical Nurse Manager was granted the Queen's Nurse award in 2022, and is a member of the Queen's Nursing Institute, a platform which provides excellent opportunities for support, networking and communication for Inclusion Health and community nursing.

A (now former) member of the team won the 'Chief Nursing Officers Award for Health Care Assistants' for their work within the team. The award recognises the vital contribution of healthcare support workers, and in this case was awarded under the category of 'Everyone In and Improving Lives'.

Section 6 – Team Referral Data

Referrals and Caseload

During the year, new care episodes were added to the team's caseload in two ways:

- Patients were referred to the team from ED, Wards and Community settings, via the team's formal referral pathway.
- The team opportunistically identified patients in ED, Wards and Community settings that meet their inclusion criteria. These may be completely new patients, or patients previously discharged from the team's caseload who need further support.

Over the year, a total of 443 formal referrals were made to the team, of which 417 (94.1%) were accepted. The team also made 201 opportunistic contacts, for a total of 618 contacts from 387 individual patients (1.6 per patient). Of the 618 contacts, 67.5% (417) came from direct referrals and 32.5% (201) from opportunistic pickups.

The team's primary source of accepted referrals was Inpatient Wards (42.2%), followed by ED (29.7%) and Community (27.8%). One patient was referred from

AMU. Contrastingly, opportunistic contacts were primarily made in the Community (47.8%), with ED (29.9%) and IP Wards (22.4%) following.

Chart 1: New Care Episodes by Source

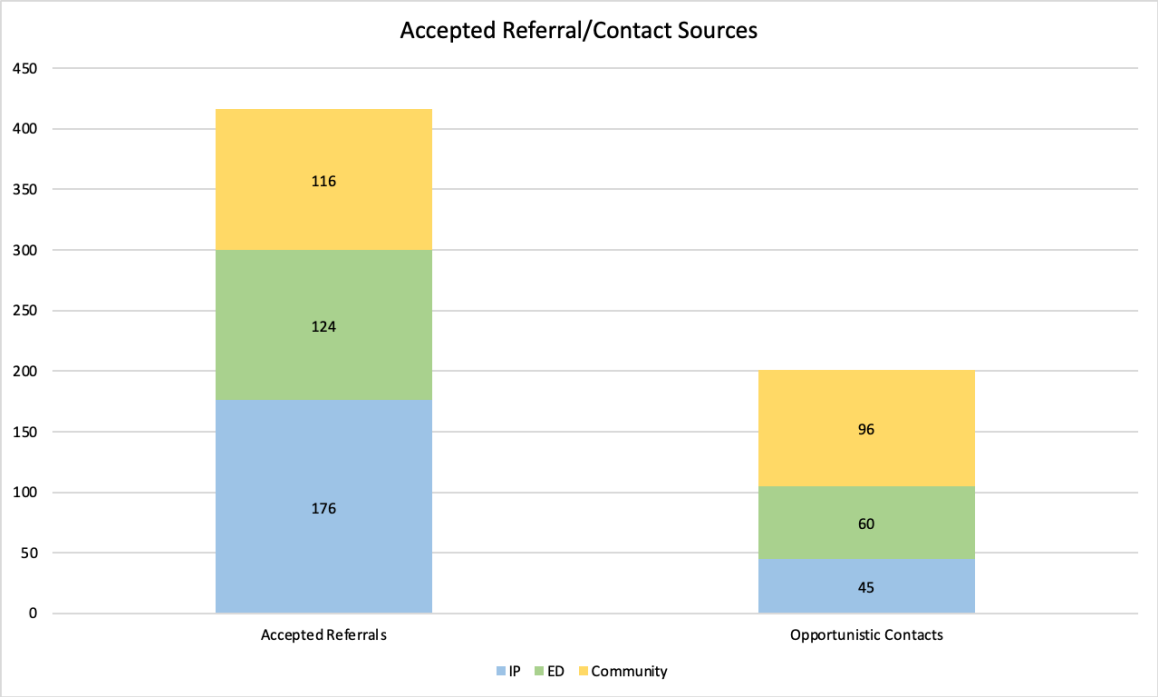


Table 1: Combined accepted referrals and opportunistic contacts, by referral source

	Total	% of total
IP	221	35.8%
Community	212	34.3%
ED	184	29.8%
AMU	1	0.2%
Total	**618**	

During the year, the majority of patients (71.6%) had only one care episode with the team. However, a small number of patients had multiple episodes with the team – in these instances patients were discharged from the team's caseload and then added back on for a new care episode following a referral or opportunistic pickup. Overall, 13 patients (3.4%) had 5 or more contacts with the team, with 2 patients having 10, and 1 patient having 15.

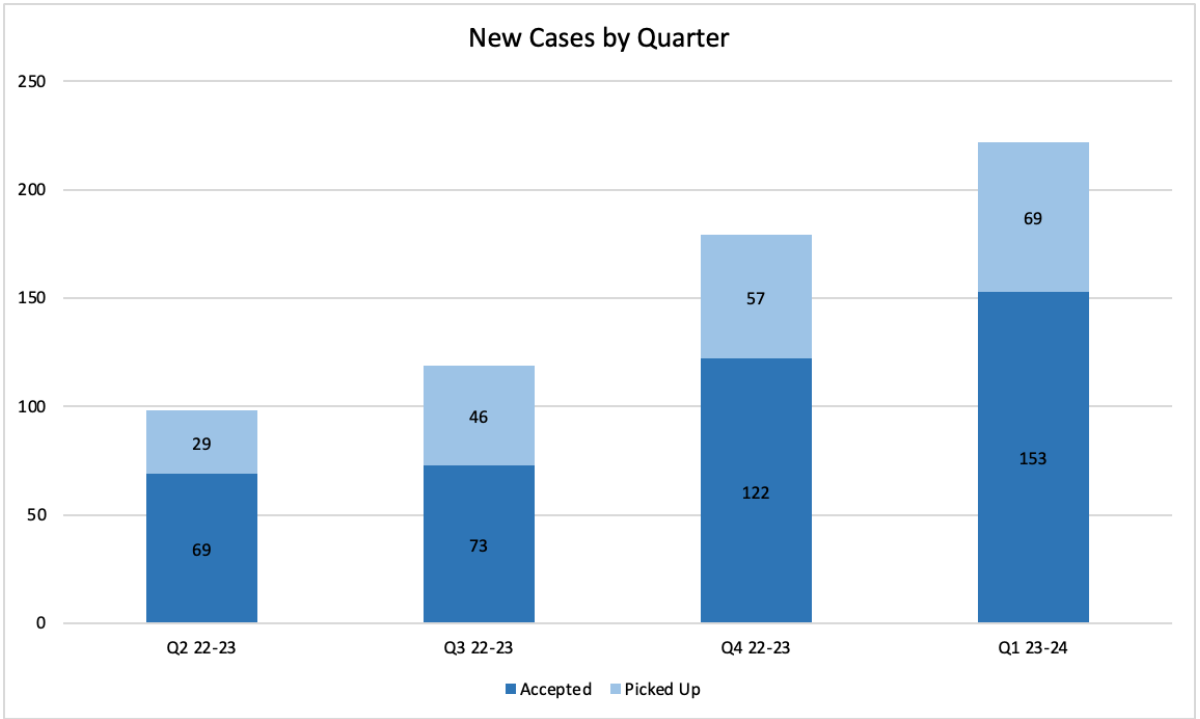
Table 2: Care Episodes per Patient

Number of Care Episodes	Total Patients	% of patients
1	277	71.6%
2	58	15%

3	26	6.7%
4	13	3.4%
5	3	0.8%
6-10	9	2.3%
> 10	1	0.3%

Over the course of the year, the team improved its recording processes, resulting in all referrals and other contacts being accurately recorded. As such, the number of referrals taken on by the team increased quarter-on-quarter, reaching 222 from April to June 2023. The increase may also be partially driven by an increase in the local demand for the service (increasing levels of local homelessness) and greater local awareness of the team (resulting in more referrals being made).

Chart 2: New care episodes per quarter

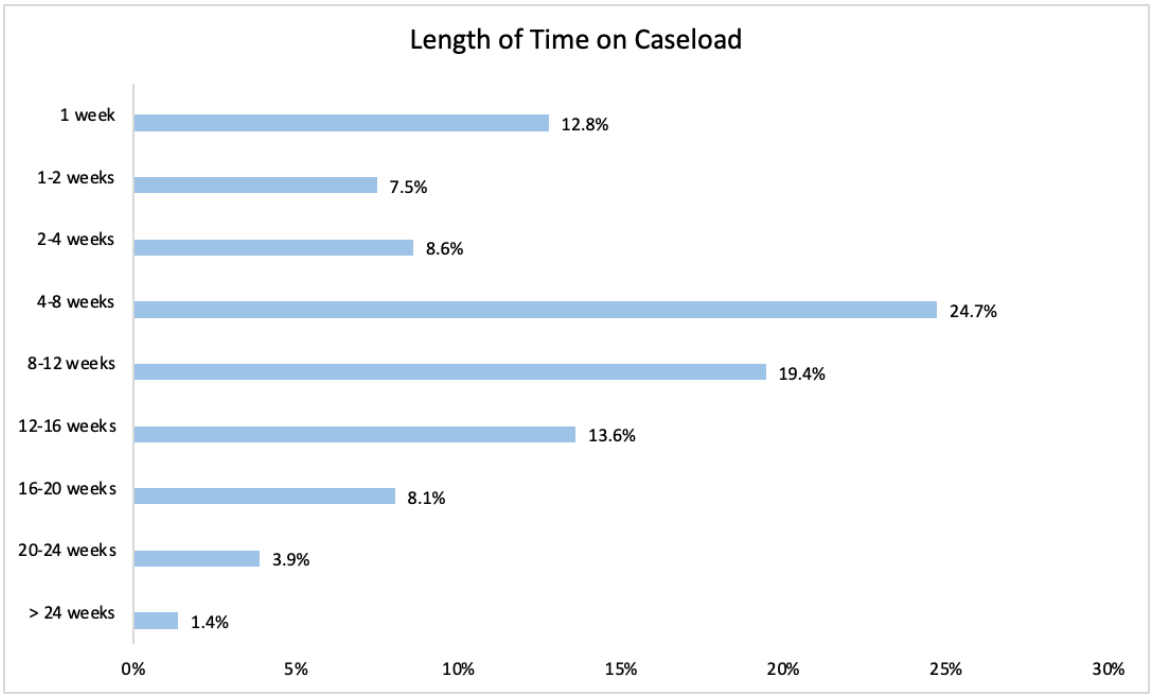


- Q2 22/23 total: 98
- Q3 22/23 total: 119
- Q4 22/23 total: 179
- Q1 23/24 total: 222

Of the 618 new care episodes started during the year, 361 (58%) were also discharged from the team's caseload. The median length of time for care episodes during the year was 52 days.

Of these 361 discharges from the team's caseload, an improvement in the patient's health and wellbeing was documented in 345 (96%) of cases.

Chart 3: Length of care episodes



Assessment, Support Plans and Interventions

New referrals receive holistic assessments (covering physical health, mental health, substance misuse, housing needs and social needs) upon acceptance to the team's caseload, along with a co-produced support plan.

Of the 618 ‘contacts’ recorded, 38 were opportunistic pickups of patients recently discharged from the team’s caseload. In these cases, a new assessment was not completed due to a recent assessment and support plan being on file. Of the remaining 580, the team assessed 100% and co-produced support plans for 96%.

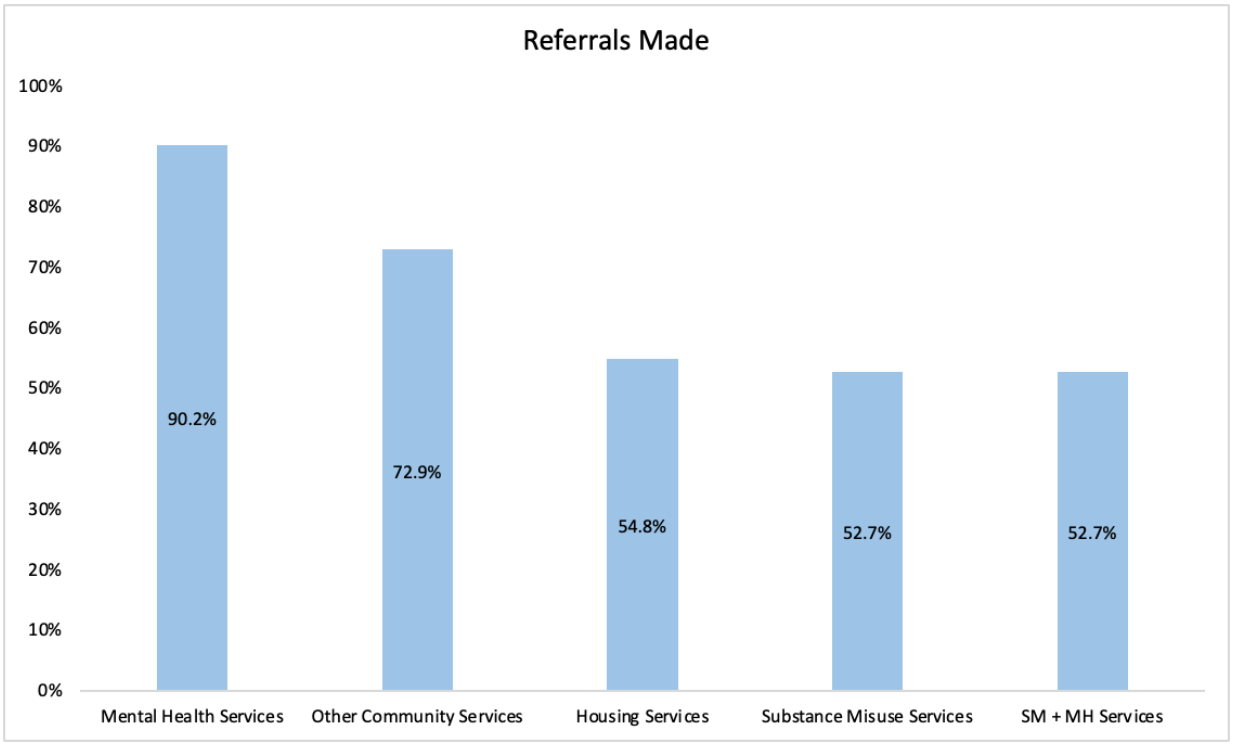
For referred patients, the team assessed 98% within two working days.

Table 3: Assessments and Support Plans

	Total	**%**
Assessment recorded	580	100%
Assessed within 2 working days of referral (of 417)	407	98%
Support Plan recorded	556	96%

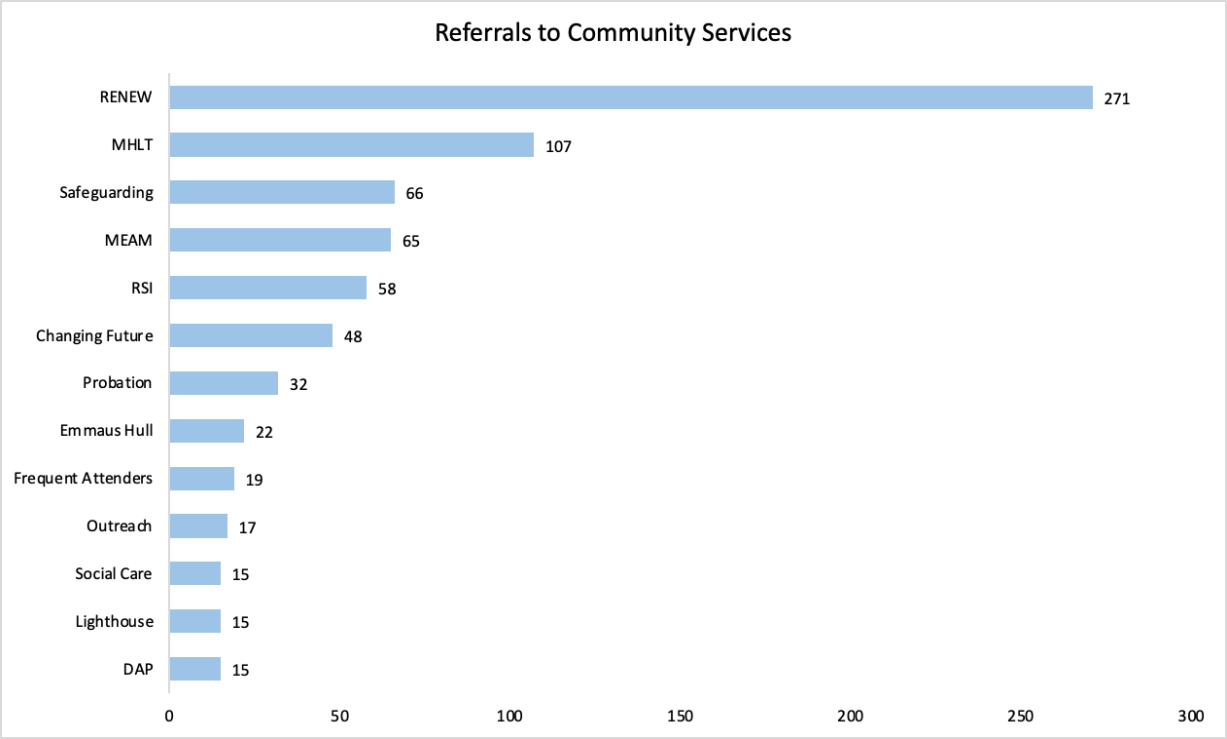
Whilst providing care, a key feature of the team’s work is to ensure that patients are appropriately referred to other healthcare and community services. Chart 4 below shows the proportion of the 387 individual patients who received a referral to different services.

Chart 4: Referrals to other services



Overall, 72.9% of patients received a referral to another community service. Chart 5 below shows the total recorded referrals over the year to the different community services that the team works with.

Chart 5: Referrals to community services



Hospital Discharges and Community Transfers

In total, 405 (65.5%) of the 618 care episodes during the year were for hospital patients (221 Inpatients, 184 ED patients). Of the 221 Inpatients, 10 were still admitted at the end of June 2023.

The team was able to successfully transfer the majority of hospital patients to the community support element of the service.

Table 4: Discharge Outcomes

	IP	ED	Overall
% self-discharge	24.5%	11.5%	18.5%
% transferred to community provision	90%	74.2%	82.7%
Inpatient Median Length of Stay (days)	7		

The data shows a very high self-discharge rate of 24.5% for Inpatients but much lower for ED at 11.5%. Typically, self-discharge rates are higher in ED settings.

The 52 recorded self-discharges for Inpatients came from 37 individual patients.

Table 5: Self-Discharges per patient

Number of self-discharges	Number of Inpatients
1	28
2	12
3	1
4	1
5	1

Housing Outcomes

The team successfully recorded housing status at admission/attendance and discharge for all hospital care episodes during the year. During care episodes, the team conducts housing support and advocacy as appropriate, including referrals to statutory/third sector housing services, providing clinical advocacy, and accompanying patients to appointments.

The data shows impressive outcomes from this work, including:

- A **52%** reduction in rough sleeping for inpatients, and a **42%** reduction in rough sleeping across all patients.
- A **46%** increase in the number of hostel placements, across all patients.
- **7%** of all inpatients were discharged to appropriate care settings, including intermediate care, rehab facilities, care/nursing homes and specialist mental health facilities.

The outcomes achieved by the Hull team differ from other Pathway team sites, where reductions in rough sleeping are generally driven by large increases in the number of Temporary Housing placements. However, this team has largely achieved reductions in rough sleeping by securing hostel placements for patients.

Chart 6: Housing status at admission vs discharge from hospital, all hospital patients

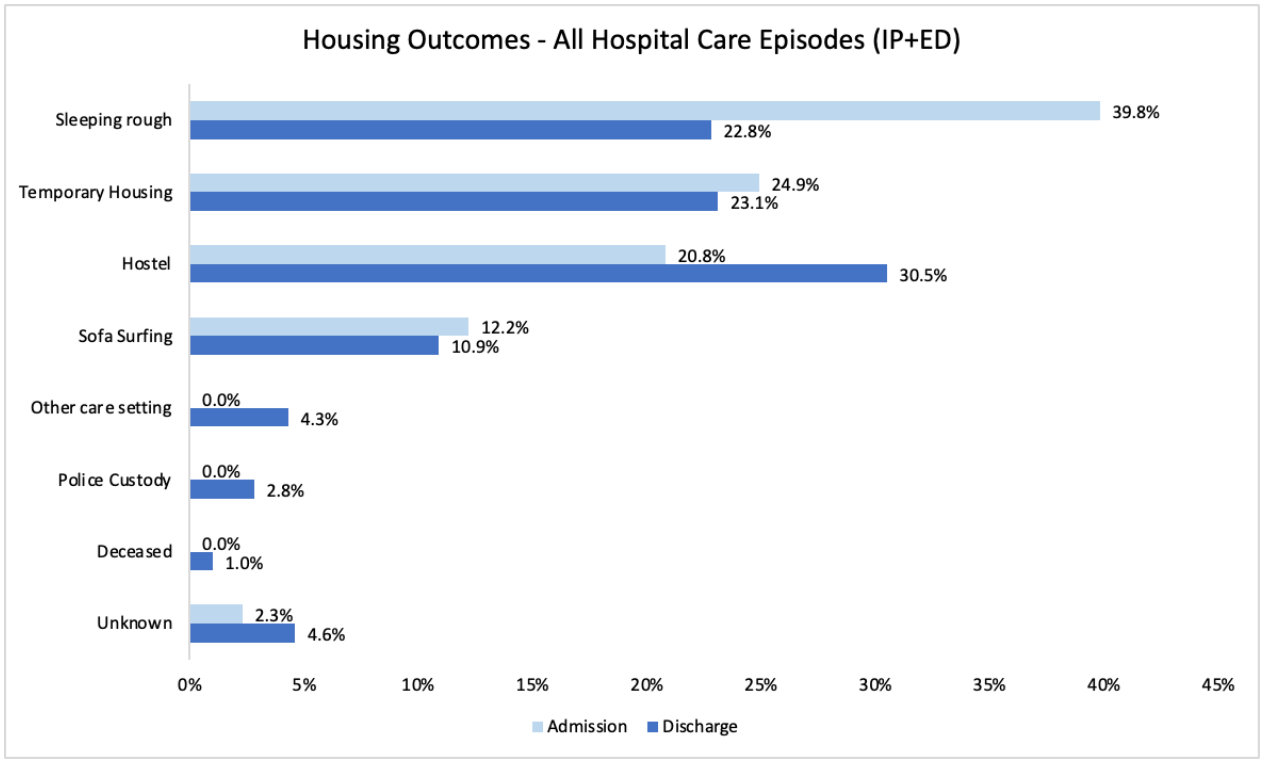
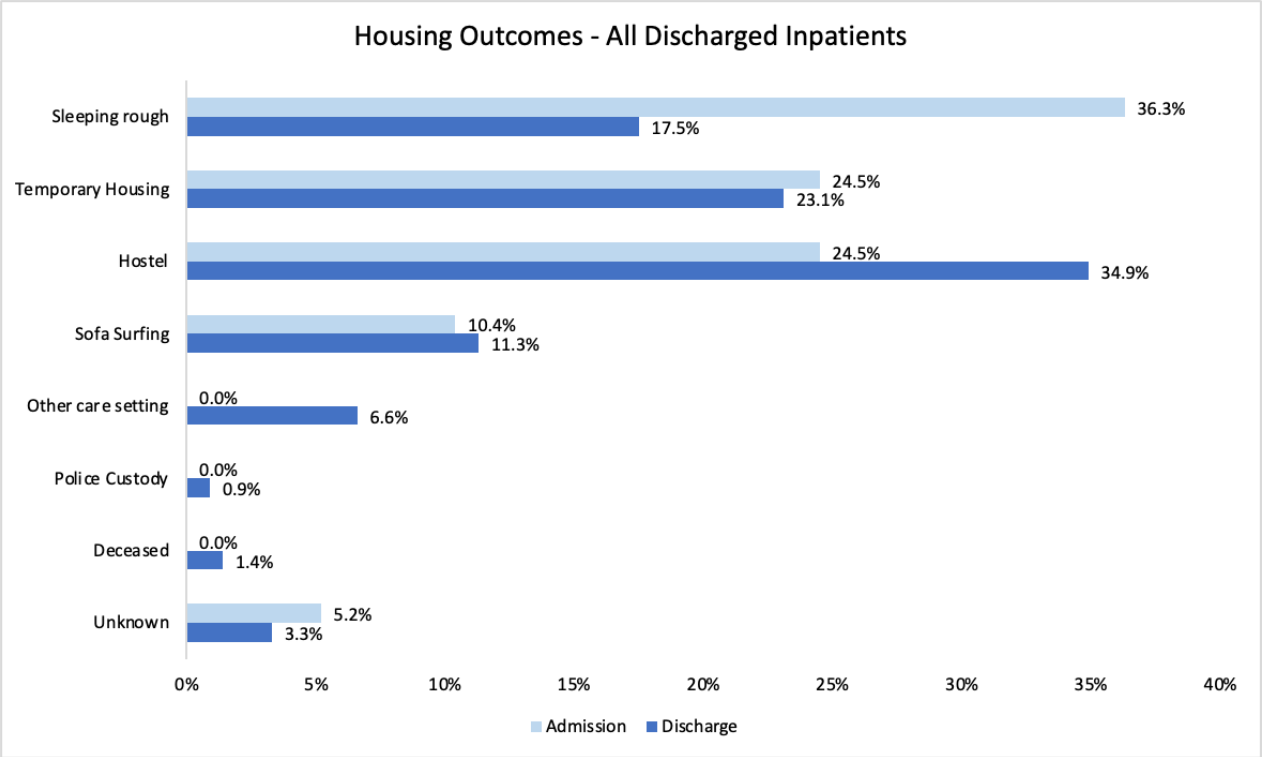


Chart 7: Housing status at admission vs discharge, inpatients only



Section 7 - Case Studies

Case studies collected by the team during the year demonstrate the range of activities the team engages with, as well as highlighting the complex challenges faced by users of the service.

Case Study 1

D is a Somalian man who entered the UK legally and was granted a Right to Reside and Right to Work for ten years. Despite this, the patient had No Recourse to Public Funds. He had applied for extended rights prior to the end date, but his application was delayed for over a year due to Home Office processing backlogs. During this time, landlords and employers become increasingly unhappy about providing support and services due to concerns about incurring penalties for supporting people without the necessary permissions.

As a result, the patient lost his accommodation and was unable to renew self-employment contracts with various employers. By late 2022, he was sleeping in his car with very little income, facing destitution due to an inability to claim benefits. In May 2023 he was in a serious car crash resulting in broken vertebrae in his neck and back. His car was written off meaning he had lost his sleeping place along with his right to work.

The team met the patient following this admission. At this point the patient was extremely concerned about his legal status and was facing stressful rumours on the

ward that he was facing deportation. Whilst the patient did have access to legal support, he had not updated them as to his current situation.

Initially the team completed a Duty to Refer to the Local Authority, they were unable to support him due to him having No Recourse to Public Funds. The team then liaised with the ward to explain the situation, who agreed that it would not be a safe discharge to discharge him to the streets. The team then updated the patient's legal support team, who requested support from a local MP. The team also liaised with the Hospital Discharge Team and the Social Work Team to pursue a Human Rights Assessment. The team also provided emotional support to the patient.

Following this, the patient was granted Recourse to Public Funds until a final home Office decision was made. The team then supported the patient to make a claim to Universal Credit and accompanied the patient to DWP meetings due to his worries about the process.

The Local Authority were then informed of the new decision and a hotel room was offered which the patient was discharged to. Unfortunately, there was a further delay to his benefits payments, for a long time he was dependent on food parcels. Following further advocacy support from the team a housing offer was made by the local council.

After 2 months, the patient had fully accessed Universal Credit, and was able to receive an advance payment. He has now been granted full rights to work in the UK, although only for a limited time. He is still working with his legal support team, who are confident that his reapplication will be successful. The patient has reported feeling much more positive about his life and has a clear direction to sustain his own recovery and stability.

Key challenges

- This was a very complex and lengthy process.
- It highlighted the difficulties faced in gaining accommodation in the UK if someone does not have recourse to public funds and is unable to work.

Key positives

- Good relationship with Hospital Discharge Team meant we communicated well, and they understood what there a delay and the problems was faced by the local authority in offering accommodation.
- Network of specialist support (immigration, legal, benefits, social work etc), assisted the team in supporting a client through unknown territory.
- Key learning for the team around immigration law and no recourse to public funds.

Case Study 2

D is a 42-year man who had been rough sleeping since losing his room at a local hostel. He was placed there following a 4-month sentence in prison. D has been stuck in a cycle of homelessness, prison sentences and addictions, facing multiple disadvantage and social exclusion.

D had poor physical health, including a bilateral leg ulceration, chronic malnutrition and a history of deep vein thrombosis. He also had a skin condition he believed to be scabies. He is a heavy crack and heroin user who has been in and out of treatment with drug and alcohol services. D also suffers from anxiety and depression and expresses paranoid and delusional fixed beliefs around the fact he has mites in his skin, and he can see them. This has prevented him from accessing housing support as he believes he is infectious to others. He suffers stigma and abuse from other service users due to his visible skin lesions and self-neglect around his wound care.

Further, D has an extensive history of complex trauma from childhood, which has been further compounded by his time spent living and the streets and in custody. He has struggled to trust services, leading to disengagement and sometimes aggressive behaviour towards staff members.

D has been known to the team for a long time, and engagement with him has always been opportunistic. Over time, the team has engaged with D through street outreach and gradually built-up trust and a rapport with him. Eventually D disclosed to the team where he was rough sleeping and allowed the team to observe his own wound dressing.

Through gentle engagement he agreed to allow the team to order some simple dressings and took advice that that would be better than him using the method he was. The team took a harm minimisation approach, accepting he was not ready to show us the wounds on his legs. After a few weeks of this, he agreed to let the team watch him dress his own legs. The team liaised with his GP and obtained antibiotics and swabbed the wounds. Eventually he allowed the team to dress his wounds and photograph them in the Hub.

D was then accepted for twice weekly slots at Story Street to have his dressings done in an appropriate clinical environment. The team took D to the Changing Futures meeting and have been involved in extensive multiagency working around him. D agreed to a referral to MEAM which the team submitted, and he accepted. He eventually agreed to a Priority Bed at a Hostel. The opportunistic engagement then led to D disclosing to the team he would consider going to a longer term hostel placement for a room, which we fed back, and he accepted a room there last week. The team have worked with probation, housing, Homeless Mental Health, outreach, Hull Bid and MEAM to support D.

A key barrier for D’s engagement with services has been his fixed beliefs around his skin conditions, and services directly challenging these. In order to engage D, the team has agreed to neither challenge nor collude with these beliefs. Providing a consistent approach across the team has allowed D to trust the service. This person-centred trauma informed approach has enabled D to now have his wounds dressed

which has given him more confidence in being able to access Housing Provision and secure more stable accommodation.

Section 8 - Patient/Staff Feedback

Patient Feedback

Throughout the year, the team has received informal feedback from a number of patients. Moving forward, the team aims to collect feedback in a more systematic manner in order to identify areas for improvement, as well as evidencing the benefit of the service.

Quotes from patients:

- ***"You are one of only a few people who have ever treated me like a human being."***
- ***"I feel heard, and not like a problem. You are on my side."***
- ***"I will never forget the help that I have received from this team."***
- ***"I am so thankful for the team that has supported me, and I cannot thank you enough"*** - this patient was rough sleeping with alcohol problems and, following the support of the team and his own engagement, is now living in his own property and engaging with Drug and Alcohol services.
- ***"Thank you for seeing me as a woman first" -*** after the team had taken toiletries and underwear to her.
- ***"You are the first person, since I was admitted, who has treated me as a person - not a druggie or a problem."***
- ***"You have made me so happy. I cannot thank you enough" -*** after the team had tracked down her sister and facilitated a phone call to her and re-established the connection.

These quotes clearly show the positive impact the team has on the lives of people who are often treated poorly and made to feel unworthy of help.

The team has also produced a short film with the help of one of their clients, as part of the *Nursing Times* award judging process.

Staff Feedback

Other hospital staff have expressed thanks to the team for the help they had given for patients on their ward. Providing specialist support for patients with complex and difficult needs is extremely valuable to hospital staff members, especially in the context of busy hospital environments. The team has received gifts, such as boxes of chocolate, from other staff as an expression of gratitude for their support.

Section 9 – Challenges and Future Opportunities

9.1 - Challenges

Despite the successes and improvements achieved by the team, the service has faced notable challenges throughout the year.

Local housing provision – during late 2022 and early 2023, the level of housing provision in Hull City has declined significantly. The closure of William Booth Hostel (109 beds) has impacted the availability of hostel provision within the city. Additionally, rising rental prices across the city have pushed landlords towards the private rental sector, limiting the number of properties available to the team's clients. In an area of high deprivation, the demand for local authority housing is high and outstrips the supply of properties. These factors provide a challenge to the housing advocacy conducted by the team.

Hospital pressures – Hull Royal Infirmary faces significant pressures in respect to bed spaces and A&E waiting times. The pressure to discharge patients often means that the team spends considerable time advocating and explain the complexity of needs and vulnerability of their clients. These competing priorities can at time cause tensions and stress on staff and working relationships. Fostering good relationships is paramount when working in such pressured environments.

9.2 - Future Opportunities

The team has identified several opportunities for improvement moving forwards.

Reducing self-discharge rates for Inpatients - the team's data showed a self-discharge rate of 24.5% for inpatients on the team's caseload. This is higher than typically seen amongst similar services and has been identified as a key area for future intervention.

Community expansion - the team is currently attempting to secure funding to expand the community element of its service, to engage in more preventative healthcare and support patients before they reach the point of needing an emergency admission to hospital. We recognise that our client group attend A & E disproportionately and often present with a high acuity leading to more complex admissions. By extending our community provision we hope to further reduce unplanned admissions.

Improving data recording - despite improvements during the year, there is an opportunity for the team to improve its data recording processes, through working with local SystmOne teams to collect data through 'homeless health templates'.

Conducting audits to identify areas for improvement - the team plans to engage a registrar to conduct audits of the service, with the goal of identifying areas for future focus and improvement.

Focusing on education to foster cultures of empathy and non-judgemental care - looking ahead to the coming year, the team recognises the need to expand educational initiatives. They plan to enhance their impact by introducing more structured educational programs. This may include workshops, seminars, and

training sessions for both our clients and the broader community. The aim is to create a more informed and empathetic environment that supports patients on their journey to improved health and stability.

Continuing professional development – ensuring that team members have access to training and education to stay at the forefront of evidence-based care and have the appropriate skills and knowledge to provide an effective and quality service for people experiencing homelessness.

Appendix A: Pathway's Quality Framework

The Quality Framework is a set of 'quality indicators' which can be used by Pathway teams to measure and improve on various aspects of service quality. Each indicator relates to a different aspect of quality. The framework was developed by the Pathway charity in collaboration with Pathway Partnership teams.

Key objectives

1. 80% of appropriate patients referred to the team are seen and assessed within 2 working days of receiving the first referral.
2. Time from admission to referral to Pathway team is monitored and reviewed at least annually - with an aim that the average length of time to referral reduces, to enable more time for discharge planning.

3. 85% of 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.
4. 80% of patients have housing status recorded on BOTH admission and discharge.
5. 100% of 'self-discharges' and 'abscondments' are recorded, and interventions put into place to reduce self-discharge/abscondment rates.
6. 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.
7. 85% of patients who do not have a GP, or who have an inappropriate GP on initial assessment, are assisted to register with an appropriate GP that they can access on discharge **AND / OR** 60% of clients will have a discharge notification sent from the team to their GP **and/or** a specialist primary care provider (including clients that have self-discharged).
8. Feedback is obtained from 10% of patients about their experience of care OR detailed targeted interviews and/or focus groups are undertaken with a smaller group of patients and quality improvement plans are put in place.