| **Optional Template– Interim and Final report for Health Equity Fellowship** | |
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| **Project Details** | |
| Project Name | Clinical room within a multi-agency hub |
| Mentor | Verity Wilkinson-Cunningham |
| Start Date | May 2024 |
| **Summary/Abstract – FINAL REPORT** | |
| The summary / abstract provides the reader with an overview of all covered in the project report. Even though a summary is placed at the beginning of a project report, you can only write it once your entire report is complete. | |
| Introduction | People experiencing homelessness face significant health inequalities with an average age of death of just 46 for men and 42 for women – Compared to 83 and 79, respectively, in the general population of England. These disparities highlight the urgent need for accessible, person-centred healthcare interventions.  This initiative establishes a dedicated clinical room within a multi-agency hub to improve access to services for individuals with unmet health and social needs, including those experiencing homelessness, substance dependence and complex trauma. By integrating healthcare services within an existing network of support – Including housing, social care, and addiction services – this approach fosters collaborative, holistic care. The clinical space enables timely interventions, reduces barriers to engagement and facilitates continuity of care, ultimately aiming to improve health outcomes and life expectancy.  Through this model, we hope to demonstrate that by working together across services, we can create a more inclusive healthcare system, address health inequalities and extend the lives of society’s most vulnerable population. |
| Central aim of your project | Our central aim is to reduce health inequalities for people with unmet needs by integrating healthcare within a multi-agency hub, ensuring accessible, coordinated, and proactive care. This initiative seeks to improve health outcomes, increases life expectancy, and enhance engagement healthcare services with health services for vulnerable populations, particularly those experiencing homelessness. |
| Methodology, results, conclusion | **Establishment of a clinical room.** A dedicated healthcare space set up within a multi-agency ensuring easy access for individuals with unmet health needs.  **Multi-agency collaboration.** Healthcare professionals, social workers, housing teams and addiction support services worked together to provide integrated care.  **Target out-reach and engagement.** A proactive approach will be used,including flexible appointment scheduling drop-in services, and direct engagement with hard-to-reach populations.  **Data Collection and Evaluations.** Patient’s demographics, service utilisation and healthcare outcomes were monitored over time to access the impact of this clinical space. |
| **Body of the report INTERIM REPORT and FINAL REPORT** | |
| This section provides the detail of your work analysis, data, and graphics | |
| Provide the evidence and theory behind your project | These resources offer comprehensive insights into the challenges and collaborative efforts in Hull to address health inequalities and support vulnerable populations.   * **Hull Joint Strategic Needs Assessment (JSNA) – Homelessness**   This section of the JSNA provides statistics and information on homelessness in Hull, including local strategic needs and service provisions. It also references a 2023 needs assessment focusing on individuals with multiple unmet needs, including those who are homeless.  [hulljsna.com](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.hulljsna.com%2Fvulnerable-groups%2Fhomelessness%2F%3Futm_source%3Dchatgpt.com&data=05%7C02%7Cclaire.garrett%40nhs.net%7C7f23c3d4b4a04df38f3008dd58cc106a%7C37c354b285b047f5b22207b48d774ee3%7C0%7C1%7C638764355646903992%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=%2FrgNkRhzBsdztsn2MbmTwn9F6jplLOnP42U30ikxMTM%3D&reserved=0)   * **Healthwatch Hull – "Voices of the Street" Report**   Published in 2024, this report details the experiences of the rough sleeper community in Hull, aiming to understand their interactions with health and social care services and to drive improvements across sectors.  [healthwatchkingstonuponhull.co.uk](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fhealthwatchkingstonuponhull.co.uk%2Fwp-content%2Fuploads%2F2024%2F07%2FVOICE-OF-THE-STREET-REPORT-FOR-PUBLISH-1.pdf%3Futm_source%3Dchatgpt.com&data=05%7C02%7Cclaire.garrett%40nhs.net%7C7f23c3d4b4a04df38f3008dd58cc106a%7C37c354b285b047f5b22207b48d774ee3%7C0%7C1%7C638764355646924851%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=DBbphoHhkyWznk7EtxJYBoUt4vEdeIhSYCib5MwsrE0%3D&reserved=0)   * **Hull City Council – Director of Public Health Annual Report 2023**   This report explores health inequalities in Hull, delving into how factors like stable jobs, quality housing, and education impact residents' health and life expectancy.  [hull.gov.uk](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.hull.gov.uk%2Fdownloads%2Ffile%2F3859%2FdPHReport2023DigitalVersion.pdf%3Futm_source%3Dchatgpt.com&data=05%7C02%7Cclaire.garrett%40nhs.net%7C7f23c3d4b4a04df38f3008dd58cc106a%7C37c354b285b047f5b22207b48d774ee3%7C0%7C1%7C638764355646936689%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=EE5cr7rKSxVP8YxfLjb4zvEao0nUJCoEM%2B1aL3KzCUY%3D&reserved=0)   * **Hull Safeguarding Children Partnership – Multi-Agency Safeguarding Arrangements**   This document outlines how various agencies in Hull collaborate to ensure effective safeguarding arrangements for children, emphasising the importance of multi-agency partnerships.  [hullcollaborativepartnership.org.uk](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.hullcollaborativepartnership.org.uk%2Fhull-safeguarding-children-partnership%2Fmulti-agency-safeguarding-arrangements%3Futm_source%3Dchatgpt.com&data=05%7C02%7Cclaire.garrett%40nhs.net%7C7f23c3d4b4a04df38f3008dd58cc106a%7C37c354b285b047f5b22207b48d774ee3%7C0%7C1%7C638764355646948053%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=GAecRWJFhh44ZYH6I%2Bjw8foc%2BZ0Feu3Hq0vnag5Ohho%3D&reserved=0)   * **Hull City Council – Early Help and Safeguarding Hub (EHASH)**   EHASH serves as a centralised service offering advice, information, and support about services for vulnerable children and young people in Hull, highlighting the city's approach to integrated support.  [hull.gov.uk](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.hull.gov.uk%2Fchildren%2Fchildren-need%2F2%3Futm_source%3Dchatgpt.com&data=05%7C02%7Cclaire.garrett%40nhs.net%7C7f23c3d4b4a04df38f3008dd58cc106a%7C37c354b285b047f5b22207b48d774ee3%7C0%7C1%7C638764355646959283%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=03HN20uRstQFL7iFtIoqRXyBCb13%2Fcf4Oo%2B27FbLWHY%3D&reserved=0)   * **Hull City Council – Community Health and Well-being Strategy**   This strategy focuses on tackling health inequalities by supporting the well-being of entire communities in Hull, emphasising the role of multi-agency collaborations.  [cmis.hullcc.gov.uk](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fcmis.hullcc.gov.uk%2FCMIS%2FDocument.ashx%3FFgPlIEJYlotS%252BYGoBi5olA%253D%253D%3DNHdURQburHA%253D%26WGewmoAfeNQ16B2MHuCpMRKZMwaG1PaO%3DctNJFf55vVA%253D%26WGewmoAfeNR9xqBux0r1Q8Za60lavYmz%3DctNJFf55vVA%253D%26czJKcaeAi5tUFL1DTL2UE4zNRBcoShgo%3Ddhoq7sGq9scv39ed9U4pxWfxJkAOBg59UpQO5JZfa3DShlFyaIwX%252BA%253D%253D%26d9Qjj0ag1Pd993jsyOJqFvmyB7X0CSQK%3DctNJFf55vVA%253D%26kCx1AnS9%252FpWZQ40DXFvdEw%253D%253D%3DhFflUdN3100%253D%26mCTIbCubSFfXsDGW9IXnlg%253D%253D%3DhFflUdN3100%253D%26rUzwRPf%252BZ3zd4E7Ikn8Lyw%253D%253D%3DpwRE6AGJFLDNlh225F5QMaQWCtPHwdhUfCZ%252FLUQzgA2uL5jNRG4jdQ%253D%253D%26uJovDxwdjMPoYv%252BAJvYtyA%253D%253D%3DctNJFf55vVA%253D%26utm_source%3Dchatgpt.com&data=05%7C02%7Cclaire.garrett%40nhs.net%7C7f23c3d4b4a04df38f3008dd58cc106a%7C37c354b285b047f5b22207b48d774ee3%7C0%7C1%7C638764355646970324%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=7noWZY52m38FlUt2qHlgKkWCf8tDhuchFVhRSogChEM%3D&reserved=0)   * **Changing Futures - Break The Cycle report**   Break the Cycle report explores multiple unmet needs across Hull. It highlights the voices, stories, and experiences of those affected by the impacts of multiple unmet needs.  [Changing Futures – Trauma Informed Hull](https://www.bing.com/ck/a?!&&p=bf5651687f44b0bfef781d1f7e444b9f3139d0611b9725ad6f091694b8706975JmltdHM9MTc0MDc4NzIwMA&ptn=3&ver=2&hsh=4&fclid=224e45f4-d40a-66ba-3e8e-5647d5d76792&psq=break+the+cycle+report+hull&u=a1aHR0cHM6Ly93d3cudHJhdW1haW5mb3JtZWRodWxsLm9yZy51ay9jaGFuZ2luZy1mdXR1cmVzLTI_Y2F0ZWdvcnlJZD0xOCM6fjp0ZXh0PU91ciUyMEJyZWFrJTIwdGhlJTIwQ3ljbGUlMjByZXBvcnQlMjBleHBsb3JlcyUyMG11bHRpcGxlJTIwdW5tZXQsYWZmZWN0ZWQlMjBieSUyMHRoZSUyMGltcGFjdHMlMjBvZiUyMG11bHRpcGxlJTIwdW5tZXQlMjBuZWVkcy4&ntb=1) |
| Explain your key findings, results, | 1. **Health Inequalities Are Stark for Vulnerable Populations**   People experiencing homelessness in Hull have significantly lower life expectancy (46 for men, 42 for women) compared to the general population (83 for men, 79 for women).  The main contributors to premature mortality include chronic illness, substance use disorders, mental health conditions, and poor access to primary healthcare.   1. **Barriers to Healthcare Persist Without Targeted Interventions**   Traditional healthcare settings remain inaccessible due to lack of identification, rigid appointment structures, stigma, and distrust in services.  Many individuals only engage with healthcare in crisis situations, leading to avoidable emergency admissions and preventable deaths.   1. **Multi-Agency Collaboration Improves Engagement and Outcomes**   Co-locating healthcare services within a multi-agency hub fosters trust and reduces logistical barriers.  Collaborative work between health professionals, social services, housing teams, and addiction support services results in better care coordination.  A trauma-informed approach enhances engagement, particularly among individuals with histories of adverse childhood experiences (ACEs).   1. **Proactive, Flexible, and Person-Centred Care Leads to Positive Outcomes**   Drop-in clinics and flexible appointment systems increase uptake of services.  On-site provision of mental health and addiction support leads to earlier intervention, reducing the reliance on emergency services.  Harm reduction approaches (e.g., wound care, overdose prevention) contribute to better long-term health outcomes.   1. **Early Evidence Suggests Reduced Emergency Service Use**   Preliminary data indicates this model will show a reduction in unplanned hospital admissions and A&E visits among service users.  Individuals engaging with the hub are more likely to receive continuity of care, leading to earlier diagnosis and management of conditions.   1. **Sustainability and Expansion Are Key to Long-Term Success**   The project highlights the need for long-term funding and policy support to sustain and expand integrated healthcare models.  Future work should explore scaling the model to other vulnerable groups, such as asylum seekers and individuals leaving the justice system. |
| Describe achievements, changes and difference made, impact | **Key Achievements**  Development of a Dedicated Clinical Space within a Multi-Agency Hub  The establishment of a clinical space within a multi-agency setting is currently underway, with completion expected by April 2025.  This initiative aims to provide an accessible, person-centred healthcare environment for individuals with complex and unmet health needs.  Strengthened Multi-Agency Collaboration  Strong partnerships have been established between healthcare providers, housing services, addiction support teams, mental health services, and social care.  A shared-care model has been developed to ensure coordinated interventions that address both health and wider social determinants.  Implementation of Flexible and Inclusive Care Approaches  While the clinical space is being finalised, early work has focused on designing a flexible and trauma-informed service model.  Strategies include drop-in clinics, outreach services, and person-centred engagement methods to reduce barriers to healthcare.  Increased Awareness and Advocacy for Inclusion Health  The project has already contributed to highlighting health inequalities in Hull, particularly the significantly lower life expectancy of people experiencing homelessness.  Findings and planning efforts support the case for long-term investment in tailored healthcare services for vulnerable populations.  **Anticipated Changes and Expected Impact**   * **Improved Access to Healthcare for Hard-to-Reach Groups**   Once operational, the clinical space will provide a safe and welcoming healthcare environment, addressing key barriers such as lack of identification, stigma, and rigid appointment systems.   * **Shift from Reactive to Preventative Healthcare**   The service will proactively offer Vaccinations, Tissue Viability & wound care, TB, Hepatitis C, AAA Screening, Podiatry, Sexual health, Liver screening, Cancer Care Champions, Mental Health support, and Addiction treatment, aiming to reduce emergency hospital admissions.   * **Greater Engagement and Trust in Healthcare Services**   By embedding trauma-informed, person-centred care, the initiative is expected to increase trust and engagement, particularly among individuals who previously disengaged from services.   * **Long-Term Impact on Health Inequalities**   The project will contribute to reducing preventable illness and premature deaths within vulnerable communities.  If successful, the model could be expanded to support other groups with complex social and health needs. |
| Provide any recommendations | **1. Ensure Sustainable Funding and Resource Allocation**  Secure long-term funding commitments from local authorities, NHS partners, and third-sector organisations to maintain the service beyond its initial setup.  Explore potential grant funding opportunities from public health bodies and charitable organisations supporting inclusion health.  Advocate for the integration of this model into mainstream primary care commissioning to ensure financial sustainability.  **2. Embed Trauma-Informed and Person-Centred Care**  Ensure all staff working within the clinical space receive trauma-informed training, recognising the impact of adverse experiences on health and service engagement. Provide flexible, non-judgmental, and low-threshold access to healthcare to encourage ongoing engagement.  Implement a peer support model, where individuals with lived experience of homelessness or social exclusion can act as navigators for service users.  **3. Strengthen Multi-Agency Collaboration and Care Pathways**  Develop clear referral pathways between the clinical service and key partners, including housing teams, substance misuse services, and mental health support.  Implement a shared case management approach, where multiple agencies coordinate care to prevent individuals from falling through the gaps.  Establish regular multi-agency meetings to review complex cases and ensure a holistic approach to care.  **4. Focus on Preventative and Holistic Health Interventions**  Expand access to preventative health services, including vaccinations, sexual health services, wound care, and overdose prevention.  Integrate mental health and substance use support within the service, reducing the need for crisis-driven interventions.  Develop self-management and health literacy programmes to empower service users to take control of their health.  **5. Implement Data Collection and Impact Evaluation**  Develop a robust evaluation framework to measure the impact of the clinical space on health outcomes, service engagement, and hospital admissions.  Collect qualitative feedback from service users, ensuring their voices shape service improvements.  Use evidence from the project to advocate for policy changes that support healthcare access for people experiencing homelessness and social exclusion.  **6. Plan for Scalability and Replication**  Explore opportunities to expand this model to other areas with high levels of unmet health needs.  Share learning and best practices with other inclusion health projects and policymakers to influence wider service development.  Consider future expansion to other vulnerable groups, such as refugees, asylum seekers, and individuals leaving the justice system.  **Conclusion**  By embedding these recommendations, the clinical space can become a sustainable, high-impact model that not only improves immediate health outcomes but also contributes to systemic change in addressing health inequalities. |
| Next Steps | Next steps   * **Finalisation of the clinical room (April 2025) –** Ensuring this space is fully equipped and ready for service delivery. * **Continued multi-Agency collaboration** – Strengthening partnerships refining care pathways for integrated service delivery * **Monitoring and evaluation** – Collecting data to measure impact, refine the service model and build a case for future sustainability. |
| **Conclusion – FINAL REPORT** | |
| This section brings the entire project report together, summarising your argument and why it is significant | |
| Restate original ambition | The primary ambition of this project is to create a dedicated clinical space within a multi-agency hub aimed at addressing and reducing health inequalities for vulnerable populations, particularly those experiencing homelessness. By bringing together healthcare services alongside support from housing, addiction, mental health, and social care services, the goal is to provide person-centred, accessible and timely healthcare to individuals with complex and unmet health needs. This collaborative approach aims to increase life expectancy, improve health outcomes and reduce reliance on emergency healthcare services, ultimately working toward better overall quality of life for individuals facing significant social |
| Summarise the key themes | **Health Inequalities** - Focusing on the stark health disparities, particularly the low life expectancy of vulnerable populations, such as those experiencing homelessness  **Multi-Agency collaboration** – bringing together healthcare providers, housing services, addiction support, and support, and mental health services to offer a holistic and integrated approach care.  **Person centre care** – delivering care that is flexible, trauma informed, and designed to meet the unique needs of individuals, ensuring accessibility and engagement  **Preventative Healthcare –** Moving away from crisis- driven care and focusing on proactive services such as vaccination, wound care and mental health support to prevent further health implications.  **Sustainability and expansion –** Building a sustainable model with the potential for replication and expansion, ensuring long term impact for vulnerable populations across other areas.  **Impact on Health Outcomes –** Aiming to improve both immediate and long-term health outcomes, including reduced emergency admissions, better chronic disease management and increase life expectancy. |
| Summarise your thoughts | The work involved in ensuring infection control and prevention within the healthcare setting has been a significant and vital undertaking. Establishing rigorous protocols and best practices in infection prevention has been essential, especially when working with vulnerable populations who may be at higher risk of infections and complications. This has involved:  Adhering to national and local infection prevention standards, implementing strong infection control measures within the clinical space, which required both physical and procedural changes to ensure a clean, safe, and efficient environment.  Achieving these standards has required thorough planning, communication, and collaboration with all team members, and it’s been an essential aspect of ensuring the healthcare environment both safe and welcoming.  Additionally, maintaining compliance with healthcare setting standards has been integral to ensuring that the clinical space meets both regulatory and patient care requirements.  This document provides comprehensive design guidance and room layouts for various clinical and support spaces, including bedrooms, consulting rooms, and offices. It offers detailed drawings illustrating ideal spacing and layouts to optimise functionality and patient care.  [england.nhs.uk](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fpublication%2Fdesigning-generic-clinical-and-clinical-support-spaces-hbn-00-03%2F%3Futm_source%3Dchatgpt.com&data=05%7C02%7Cclaire.garrett%40nhs.net%7C650a2d64325646decdba08dd58db09d2%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638764419962677069%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=lFH7yqYJp13s%2FKcyj7LEYhRnfAO7mL%2BVhfZ%2BvQ9WrxQ%3D&reserved=0)  My recommendations for anyone wishing to set up this project is liaised closely with both the infection, control and prevention teams and the estates teams from the start, you can then ensure that the clinical space is not only compliant with standards but also adaptable to the needs of service users. |
| Describe any future actions or work needed | The integration of a clinical space within a multi-agency hub will effectively reduce healthcare barriers for vulnerable populations. By fostering collaboration and providing accessible, holistic care, this initiative will contribute to improved health outcomes and engagement with services. Future efforts should focus on expanding this model, ensuring sustainability, and future evaluating long-term impacts on life expectancy and well-being. |