SPCT Inclusion

Pathway Homeless Health team

First year report

July 2021 to June 2022

Northern Care Alliance

NHS Group

Executive Summary

The Salford Primary Care Together business case was developed as a result of the new Homeless Service model being approved by the Integrated Community Based Care Commissioning Group (ICBCCG) in September 2019.

The ICBCCG tasked the Homeless Re-design Task and Finish Group to look at how the new model could be implemented within the current cost envelope. The task and finish group, which comprised of members from the CCG and Salford Primary Care Together (SPCT), concluded it was not possible to implement the new model within the current budget.
The proposals for the Homeless Service were then taken to the SPCT Finance and Contract meeting. The meeting concluded that a business case should be produced to set out options to implement the new model.

The new model was designed to improve access and engagement in relation to health support for homeless people in Salford.

The new approach introduced a pro-active model of care to support people experiencing homelessness and to ensure a holistic approach to supporting individuals. This consisted of additional staffing, including and nurse and a case manager. These new staff now support people experiencing homelessness with a weekly multidisciplinary team meeting to discuss new and complex patients, visits to temporary accommodation, and a hospital in-reach 'Pathway' model discharge service was launched in July 2021. Weekly hospital in-reach sessions are undertaken.

The Pathway model offers a new way to help people who are experiencing homelessness. It trains NHS staff to help patients access the accommodation, care and support they need to recover and get life onto a better pathway after their stay in hospital.

Traditionally, Pathway teams are led by specialist GPs with a team of Nursing staff to manage the team caseload, Housing specialists bring their expertise to the service and help build links with voluntary sector services in the community. Some Pathway teams also include Care Navigators who have personal experience of homelessness, and larger teams also include occupational therapists, social workers and mental health practitioners.

Teams work with patients to create bespoke care plans for their support, including referrals to addiction services, ongoing treatment for health issues such as hepatitis C and tuberculosis, and community services offering social care. Coordinating input from housing departments, mental health and addictions services, social services, community and charity sector partners, Pathway teams provide empathetic, patient-centred, recovery-focused care.

Pathway teams:

- Provide expert advice and clinical advocacy around homeless and inclusion health issues (such as substance misuse and substitute prescribing) for inpatients, improving care and treatment outcomes
- Ensure patients with complex needs are able to engage with health and other services through holistic inpatient support and care, thereby reducing rates of early self-discharge
- Help homeless patients find somewhere safe and appropriate to stay on discharge, taking into account their needs around health, care and general support
- Support patients with financial issues, welfare entitlement and to access specialist legal help where possible
- Help to replace lost ID documents
- Ensure patients are registered with a GP for ongoing care
- Refer and signpost to specialist community services to help with a variety of social, mental and physical health, and addictions issues
- Reconnect patients to family and social support networks on discharge

Background:

The term 'homeless' is often associated by the public as people who sleep rough, in this context the term includes anyone who does not have a secure home.

For example, people whose accommodation is insecure; those facing eviction, living in temporary accommodation, sofa surfing, squatting, people at risk of violence, those housed in property potentially damaging to their health, and those who cannot afford their current accommodation.

In a report commissioned by Crisis, *Homelessness: A Silent Killer* (2011) the average age of death of a homeless person was reported as 47 years for men and 43 years for women (compared to 77 years for the general population).

- Drug and alcohol abuse are particularly common causes of death amongst the homeless population, accounting for just over a third of all deaths
- Homeless people are over nine times more likely to commit suicide than the general population.

A study from the charity Groundswell *Room to breathe* (2016) estimated that smoking rates in homeless people to be 85% in comparison to around 18% for the rest of the population.

A Homeless Link survey *Homelessness and health research* has highlighted that:

- 41% of homeless people reported a long-term physical health problem (compared to just 28% of the general population)
- 45% had been diagnosed with a mental health problem (compared to 25% of the general population)

- 36% had taken drugs in the past six months (compared to just 5% of the general population).

Salford City, Greater Manchester in context:

The city of Salford covers 37 square miles and has five districts: Eccles, Worsley, Irlam and Cadishead, Swinton and Pendlebury with a population of roughly 220,000.

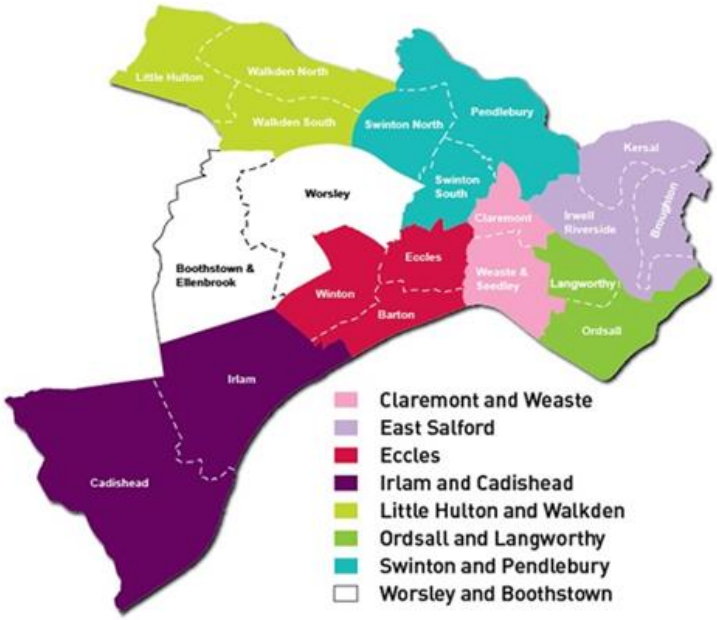
The Blackfriars, Broughton and Ordsall districts of central Salford are just one minute's walk from the heart of Manchester city centre- just across the River Irwell which runs between the two cities.

Salford is the 18th most deprived local authority area in England (out of 317) and is the third most deprived district in the city region. There are 76,400 people (30.4%) who reside in a highly deprived area of Salford, however not everyone living in an area of high deprivation will themselves be highly deprived. A Further, 10,500 residents of Salford live in areas of extreme deprivation. (Intelligence Briefing: Indices of Deprivation 2019)

At the end of 2020, there were approximately 1160 active homeless cases open in Salford and approximately 1000 individuals in the Asylum Seeker cohort.

People are housed in statutory accommodation, emergency accommodation and with independent registered providers. This includes hostels, dispersed properties: HMOs and self-contained flats.

The Rough sleeping snapshot in England: autumn 2021 report states that 8 people were identified as sleeping outside.



Service Description:

Team make up

The Salford SPCT Pathway team is made up:

- ANP (Liz Farrell 37.5 hours)
- GP (Rhianna Price 7.5 hours)
- Case Manager (Becki Smee 37.5 hours)

The team is also enhanced with the support (via the OOH care model project pathway) from:

- Dual Diagnosis Practitioner (Emma Dallyn GMMH)
- Housing Officer (Emma Davies Salford Council)

The service benefits from the fact that it is embedded in the SPCT Inclusion GP Practice which is an enhanced offer of primary care, to support people experiencing homelessness and other vulnerable groups such as Sex workers and the travelling community. The team provides cover Monday-Friday 9-5pm.

Salford Primary Care Inclusion Service:

The Inclusion Service is a specialist GP service with the aim to remove barriers to accessing health care; registering patients who have no fixed abode with links to Salford. This includes people who are rough sleeping, sofa surfing, staying in emergency or temporary accommodation such as hostels, hotels, B&Bs.

- Patients are not asked for ID and immigration status is irrelevant
- Face to face appointments are offered in Eccles Gateway, The Willow Tree surgery in Broughton and Salford Loaves and Fishes in Pendleton
- Outreach visits are arranged where required

On a monthly basis, clinical members of the team join Salford Council Housing Officers on a morning street walk to engage with rough sleepers bedding down around the city. This provides opportunity for street engagement and immediate and necessary street health intervention. It is also a fantastic opportunity to build relationships with people who may be wary of accessing primary health care and understand the barriers that people can face.

What does the Pathways team do?

For all referrals made to the team, an assessment of physical and mental health needs; housing and residency; safeguarding and social support needs is made to identify what is most important to the person. Support, encouragement and advice is offered and with consent, the team will work with the individual to develop strategies for looking after their own health.

This information is gathered to inform the co-production of a bespoke care plan for the appropriate discharge of the patient. The care plan is devised in partnership with other hospital and community staff across a variety of statutory and voluntary sector agencies. Equal priority is given to the provision of appropriate housing and linking patients into appropriate health care.

All patients are offered the opportunity to register with the SPCT Inclusion Service, although this is not necessary for the team to offer support, the team will also support in reconnecting with the patient's own GP or registering with the most appropriate service.

The team will refer and signpost to specialist community services to provide ongoing help with housing, social, mental, and physical health and addiction issues. Where a patient needs hands-on support immediately post discharge e.g. to manage medication, rearrange a flat, access health care this can be given. An emphasis is placed on building a positive relationship with services that will build trust and endure.

Overall, the service aims to be a presence in the hospital and assist in decision making around people experiencing homelessness and their unique set of circumstances. We offer support with the discharge back into the community and continue their care, improving quality of life and health outcomes with the aim to reduce delayed discharges and repeat attendances.

The foundation of the team's approach is based on the Pathway team social franchise manual and training. This is also additionally supported by monthly calls from Pathway.

Referral pathways, MDT meetings and community links:

The team supports people identified as experiencing homelessness in the Emergency Department or who have been admitted to Salford Royal Foundation Trust Hospital.

As the service becomes more well-known, hospital staff are increasingly referring more patients. Most of the referrals are made by the integrated discharge team, however direct referrals from Meadow Brook mental health unit, wards and Emergency department streaming nurses are on the rise.

One challenge has been the delay in referrals from the hospital to the team, often the patient is medically fit for discharge the day of referral and staff hope that we are able to assist in discharge that day, we must remind the hospital staff that we are advocating for a safe and appropriate discharge, and this can, at times, result in the patient needing to stay in hospital a little longer.

204 referrals have been made in the first year and the main aim has been to respond swiftly, ensuring a member of the team have been in contact with the patient/referrer in 1-2 days of receiving the referral.

The weekly multi-disciplinary team meeting is well attended and effective. Representatives from the RSI team, housing, community mental health services, palliative care team and Achieve and RSDA team (community substance misuse services) regularly attend. Hospital ward staff are also invited to attend to discuss their patients, and they are actively encouraged to be involved. Once a month, one member of the team also attends the RSI (Rough Sleepers Initiative) meeting and the Duchy Partnership meeting. The team are also involved in the quarterly Salford Council Homelessness Strategy Monitoring Group.

Housing Step Down – Out of Hospital Care Model Project:

The GM proposal for 2021/22 was to work with a single locality (Salford) to establish a Discharge to Assess model for people experiencing homelessness when leaving hospital. This allowed for a pilot to test and learn from an alternative 'housing-led' step-down pathway from hospital for people who need time for recovery and reablement. The provision was funded for a period of recovery following a hospital episode, in a safe environment, with the right support available (housing and clinical) and opportunity to move on to more permanent accommodation.

The aims of the model were:

- Support a timely discharge from hospital, freeing up much needed capacity without the risk of a discharge to the street.
- Support transition between inpatient hospital settings and the community.
- Acknowledge that individuals experiencing homelessness may still be unwell at the point of discharge and are likely to require ongoing support.

- Allow the implementation of 'Home First' discharge to assess for this cohort through the provision of appropriate and stable accommodation for an agreed period of time after discharge.
- Ensure that the care plan on discharge and requirement for any ongoing reablement is shared with professionals supporting the individual and implemented.
- Provide clinical support through primary care in-reach (either specialist GP or nursing input) for any ongoing medical need, particularly for those who are clinically vulnerable or have multiple comorbidities.
- Provide housing led support which is person centred and supports the individual to access relevant services, and to engage in plans for move on into alternative accommodation.

This model would also provide an important component to other elements of system change currently being implemented in Salford around homelessness and interactions with secondary care. This includes clinical staff from the Inclusion Service embedded in the hospital to support the discharge process and a Housing Options presence in ED to reduce the need for admissions from this cohort.

8 self-contained properties with disabled access were allocated to the project by For Housing and in the hospital, patients were identified using the following criteria:

Individuals will be identified as being suitable for this provision after an interaction with secondary care and meeting the scheme criteria

- Acute illness/infection with oral treatment to continue
- Have ongoing care needs that would be defined as Pathway 1 or 2 in the NHS Discharge to Assess model
- Palliative patients (not necessarily end of life): those with identifiable life limiting illness, but also those who meet the criteria in SPICT tool http://www.spict.org.uk/the-spict/ this should include end stage liver disease, late-stage COPD
- Amputations or significant mobility issues requiring adaptations to accommodation
- Ordinarily reside within Salford

During the project, 10 people were discharged via this pathway with the offer of:

- An enhanced offer of primary care – home visit on discharge from the team and weekly telephone GP consultations
- An allocated Housing Outreach worker to support with settling in, any welfare concerns, food packages, transport to and from appointments ect
- An enhanced offer of mental health and addiction support from a Dual Diagnosis Practitioner
- Fortnightly MDT meetings for continuity of care

Outcomes:

- 1 person offered property as own tenancy
- 7 people ready for move on into own property
- 2 planned deaths

Community Follow Up:

The team routinely provides follow up with patients at 2 weeks and 6 weeks after discharge, this predominately is provided over the telephone, or when the person is registered with the SPCT Inclusion Service, in clinic. Anyone who the team has struggled to contact and follow up is raised at the weekly MDT, which usually provides some information on the person's whereabouts.

All patients are signposted to and made aware of Loaves and Fishes; this is where the Inclusion Service is based so provides a simple point of access to health care but also provides:

- Free hot meals
- Food bank
- Free clothes and toiletries
- Showers
- A fortnightly Optometrist drop-in clinic
- A housing advice and support drop in run by Salford Council
- Support for people in employment skills and training
- ESOL (English for speakers of other languages) course
- A basic to advanced IT and computer course
- Weekly yoga classes
- Arts and Craft Groups
- Referrals to Citizens Advice Bureau and
- Support with finances

Emergency Department presentations and frequent attenders:

In order to identify frequent attenders to ED, the team attend the "Frequent attender" meeting ran by the Emergency department, this provides opportunity to discuss selected patients and plan a multi-disciplinary approach to the individual's care.

Links have been made and training delivered with ED staff and the Admission Avoidance team to elevate the profile of the team and encourage referral into the service.

Although the number of individuals registered with the Inclusion service attending ED has continued to rise, this is balanced against the relative increase in actual numbers of patients registered. It is hoped that more will be achieved in this area next year and this is a focus area for year 2.

Hospital Culture:

The team has focused initially on building relationships with the ED staff, Streaming Nurses, and hospital security team. They have been trained on Pathway service objectives and encouraged to contact the Pathway team with any concerns, even if not a referral.

This relationship building is beginning to prove beneficial however due to the high number of staff, more work is needed in this area to ensure that all staff know about the team.

The team are also working more generally on hospital culture and taking opportunities to market the service to elevate the profile, this has included: ward visits, posters, simple referral sheets, training sessions, sourcing champions on the wards and networking with other teams.

Case Studies:

Case Study 1: * Patient's name has been changed to Adam for anonymity*

Adam is in his 30s. He has been known to the local Housing and mental health team over the last 5 years and had experienced homelessness due to his excessive alcohol use in an attempt to numb child and adulthood traumas. When the Salford Inclusion Pathways team met Adam, he had presented in ED after spending some time out of area. He had disengaged from services, stopped his medications, and was involved in a relationship which he described as toxic. Adam presented tearful, unkempt, and covered in bruises, he stated he was "desperate for help" and that his drinking was "ruining his life."

"I had to leave the flat I was living in and was told I could not be housed as I had no local connection, I used the last of my money to get a train to Manchester and visit my sister. I knew I could not stay with her for long because of her children, it would not be fair – I needed to stop drinking but I was scared."

Adam told the team he had children who he had lost contact with and had increased his drinking to roughly 1 Litre of spirits a day since leaving the army, 4 years ago. He wanted to detox but had had a seizure the last time he tried. He agreed to accepting support from the Pathways team upon discharge but did not have a phone; he consented to the team making contact with his sister and providing her with a phone for him.

The team advocated for Adam with hospital staff and encouraged him to stay in ED to be assessed. After spending some time on the medical admissions ward, due to deranged Liver function tests, he was transferred to a RADAR bed at local detox unit. The aim of the Service is to provide rapid access for patients from acute hospitals across all general hospitals in Greater Manchester presenting with alcohol dependence or acute alcohol withdrawals who would otherwise require admission to an acute hospital bed.

In the meantime, the team contacted the Salford Housing team to make an application for accommodation. Adam was able to return to his property that he occupied before leaving Salford and was linked back up with his supported tenancies worker who specialises in supporting veterans, she supported him in dealing with the rent arrears that had built up while he'd been away and prevented eviction.

From the Detox unit, Adam contacted the team to check in and organise support upon discharge, he was registered with the Inclusion GP service to promote wrap around care, and during the weekly MDT he was discussed with the local Drugs and Alcohol Community team who agreed to provide Outreach support upon discharge.

Weekly reviews allowed the team to monitor Adam's progress and support as and when needed. There are ongoing challenges. Adam finds working with the Community Drugs and Alcohol team difficult and he is also finding it hard to budget to meet his basic day-to day needs but the team are on call to provide regular support to help him maintain the progress made. He has abstained from alcohol since his detox.

During the last call, he shared that he had accepted a full-time job which he is looking forward to starting to keep him busy. His long-term plan is to reconnect with his children once he is more settled, he said he feels like to he is on the road to a good place.

Case Study 2: * Patient's name has been changed to Paul for anonymity*

"*I know I need to stop or I'm going to die, I don't want that for my kids and grandkids*!" were the first words that Paul uttered to the team at his bedside, "*I've been through all sorts, seen so much violence and never spoke to no-one about it, that's why I am here."*

Paul reluctantly had been admitted to hospital with a groin abscess due to IVDU, he was prescribed IV antibiotics but unfortunately the staff looking after him had been unable to canulate him and oral antibiotics were instead given.

Paul disclosed to staff that he was unsafe to return to his property, as it had been turned into a trap house, and the gang who were operating from there had been controlling his life for months, "*I've been grafting for my habit, they've taken everything, even my passport – I've only got what I am wearing."*

The staff were finding it increasingly challenging to encourage Paul to stay on the ward, he was prescribed Oramorph for his pain but in his words, "*it did not touch the sides*" he wanted a heroin substitute, "*Otherwise I'll keep leaving the ward to score*." He confessed. As Paul had not been in treatment and prescribed methadone for several years, the hospital was unable to prescribe him a bridging script (as per policy.)

The ward referred Paul to the Hospital Housing Officer who carried out a joint visit with the Pathway team. Paul was open and honest and explained that he had been spending between £50 and £150 a day on heroin and crack cocaine and had been living like this for roughly a year, since being released from prison. He stated he was desperate for help and had tried ringing Achieve (the drugs and alcohol community team) but had been unable to get through. He had not engaged with his GP for some time and had several unmet health needs, including poor medication compliance, he was prescribed life-long Antibiotics following a splenectomy.

The ward was eager to discharge Paul as he had come to the end of his antibiotics, and he was concerned he'd be "*kicked out*" and his only option would be to return to the cuckooed property or sleep on the streets. The Housing officer and team advocated that he was not discharged until a property was ready and encouraged Paul to stay. In the meantime, the team referred Paul to the Achieve Outreach service to support his addiction needs on discharge.

Once discharged to a self-contained property, in an area deemed safe, Paul was followed up and supported by an Assertive Outreach Worker, the Pathways team, and the Inclusion Service. He was later referred to the Salford Dual Diagnosis Homeless Team as the community mental health service declined his referral due to his drug use.

At times, the professionals working with Paul may find it challenging to engage with him and there have been occasions where he has dropped out of services, however the weekly MDT meeting have provided opportunities for professionals to share concerns and create a plan of action. Paul knows that the services involved have an open-door policy and we will continue to be ready to support him. He has maintained his tenancy and engaged in addressing some of the unmet health needs identified.

Case Study 3: * Patient's name has been changed to Paul for anonymity*

We first met Lucy, sat on the end of her bed, despondently staring into space, the Housing Officer at the hospital had arranged a joint meeting to support her discharge planning as her poor health was as much of a concern as her lack of housing.

We introduced ourselves and began to explain why we were there, "*I just want to get out of here*," Lucy muttered, barley lifting her head. As we spoke, we explained that we could help her with that, but we needed to do it safely, she agreed to work with us.

Lucy had been in hospital for 3 months and had a diagnosis of liver cirrhosis and chronic liver disease. This was due to her previous Hepatitis C infection, deemed likely secondary to her previous intravenous drug use. She was on the Liver transplant list under the care of St James' Hospital. Self-neglect, low mood and suicidal ideation were concerns whilst on the ward, however Lucy was adamant this was due to her being "*trapped in hospital*."

Meeting the Out of Hospital Care Model Project criteria, Lucy was discharged from hospital via this pathway to a self-contained property not too far away from her family, which was very important to her. "*I love it*!" was her response when asked how she was settling in.

She was allocated an Outreach worker, support from a Dual Diagnosis Practitioner and continuous support from the Inclusion GP Service. Relationships were built with her twin sister who was also providing a great deal of support to Lucy.

Unfortunately, she had several re-admissions to hospital with features of decompensated liver disease, including bleeding from her gut due to liver cirrhosis, hepatic encephalopathy (confusion due to liver cirrhosis) and severe liver and subsequent kidney failure. During these readmissions, the team had to continuously advocate for her package of care to be reviewed and in place to prevent rehospitalisation. During some of these admissions, Lucy presented as aggressive due to her confusion, however due to previous mental health diagnoses, this was not always recognised. A care plan was written and shared with the ward in the hope of alleviating some of the barriers and frustrations both the ward and Lucy were feeling. Due to her being part of the project, Lucy was able to maintain her tenancy at the property, without this pathway, this most likely would not have happened.

The team had taken part in the "Complex Needs Training" facilitated by St Ann's Hospice which provided opportunities to build links and connect communities to support people experiencing homelessness with advanced ill health and were able to draw on support from this community of expertise.

After another admission to the ward and a lengthy discussion with family and palliative care, Lucy made the decision to stop all treatment, "she wants to go home to die, and by home, she, means the flat," her sister said.

Plans were put in place to enable this wish and Lucy was able to return to the place she called home, her family were by her bedside and the team continued to advocate for and support the family. After a short time at home, with Lucy's consent, she was admitted to St Ann's Hospice where she passed away in a dignified, comfortable way in a place of her choosing."

This case study is a powerful example of the importance of teamwork, not only between the enhanced Pathway team that the Out of Hospital Project allowed for but also with the larger MDT community that the St Ann's Hospice and Caroline Shulman training helped to develop.

Data and outcomes:

Referrals 204 referrals, 122 accepted.

Average time to pick up referral – 1.5 day

All referrals contacted and assessed before decision made if patient needed further support from team.

Reasons for rejection/no further action:

- Patients accommodated in care homes/ IMC
- Declined support
- NOK felt health needs not unmet
- Housing issue rather than health predominantly property condition

Housing status on referral:

Housing status	Number	Percentage
Rough Sleeping	3	2.5%
Sofa Surfing	58	47.5%
Temporary accommodation	55	45%
Unknown/ other	6	5%

Housing status on discharge:

Housing status	Number	Percentage
Rough Sleeping	0	0%
Sofa Surfing	13	11%
Step down	8	6%
Temporary accommodation (ABEN/RSI/bidding for own property)	96	79%
Unknown/ other	5	4%

Overall housing outcomes:

- 100% reduction of people returning to rough sleeping from hospital
- 36.5% decrease in people sofa surfing
- 96% of patients discharged to a known address where able to follow up in community

Further data:

Referral pathway	
Referred by IDT	125
Referred by Meadow Brook (MH)	29
Referred by Ward	23
Referred by A&E/streaming Nurses	27
Referred by Wider team	
Demographics of people accepted by in-reach team	
Gender: Male	96
Gender: Female	25
Gender: Not stated / prefer not to say	0
Age: 18-25	13
Age: 26-35	24
Age: 36-45	34
Age: 46-55	25
Age: 56-65	17
Age: >65	9
Ethnicity Response	
White	107
Black-Caribbean	
Black-African	5
Black-Other	
Indian	1
Pakistani	1
Bangladeshi	
Chinese	
Mixed other	3
Other	5
Not stated / Prefer not to say	
Housing	
Sofa Surfing	58
Temp/emergency accommodation	55
Rough sleeping	3
Other	6
Welfare Status	
Given advice	25 referred into Loaves and Fishes/CAB
Likely or known NRPF	6
Migration history and status	
UK national	109
Non-UK national	13

Unmet Health Needs data/referrals:

Assessment:	**Response:**
Consent to full unmet health needs assessment	72
Offered advice only	17
Signposted to out of area services	14
Declined further support	6
Unable to contact	3
Other	
Support given:	
GP Registration	33
Medication concordance	37
Dressings	15
Signposted/ engagement with mental health	28
Signposted/ engagement with addictions	19
Referral to LA - Safeguarding	
Referral to LA - Care Act Assessment	1
Physiotherapy	1
Occupational therapy	
Dental	Shared drop in emergency info with all
Optician	Shared drop in info with all
Podiatry	1
Vaccination	15
Screening (any type)	
Other	

Patient and professional feedback:

As part of our plans for next year, we are looking at alternative ways to collect feedback from patients, here are some examples of verbal feedback the team have received:

Patient feedback:

"I was so pleased to see a familiar face, that's why I jumped up to hug you!"

"Thankyou for listening to me and not fobbing me off."

"Me and my family are so grateful for the support your team gave to us all."

"I think I am ready to move on now, thank you for your help!"

Professional feedback:

For my role, I have found being part of Inclusion Health GP MDT vital in supporting protect clients. All the health research for homeless health shows that homeless people are at risk of tri-morbidity (MH, SMS, physical health). Having a platform for us to all to discuss clients weekly really safeguards this risk.

I think the regular meetings also offer preventative work, and quick response to any crisis situation. Having close links to your service has increased safeguarding planning and involvement. We have had some really complex cases, where without our MDT working, I don't think the person in each case would have had the timely, appropriate response that we have seen.

I think us working together strengthens community working, and as a group we have more influence on the system that an individual. I know our clients have provided positive feedback to the quick response we have had from your team.

For me personally, I really valued the most your help with AM, and I am sure we would not have supported him into temp accommodation if we had not worked as a broad MDT for this chap- housing, mental health and physical health.

Outreach general nursing is amazing and saves lives. This is key to working with our most vulnerable clients. We have valued having ANP's for our clients, and swift GP appointments when needed. The person-centred approach is trauma informed and fits with the values of our service. Collaboration is key.

I value our way of working in Salford and hope we can continue to build a gold standard service. I would be more than happy for us to co-facilitate some training at some point around homeless health for the wider community. We can link in with the good work of XXX in Manchester and show case some of the work we have done to date.

Please could you forward this to X- I don't have any contact for her.
Just wanted to say a massive thanks for yesterday with X's appointment. On the way there he was quite nervous and said that he hates going to GP's as he feels he's always just treated like a junkie and isn't listened to properly. Afterwards he said that he really liked X and how different his appointment was compared to any other he's had before. He's engaged really well with X today and seems like he's keen to stay in touch with the team after yesterday's appointment.

Summary and Plans for Year 2:

This report has demonstrated that the new Salford Pathway team has began to make an impact on partnership working between the hospital and the community in terms of the response to homelessness. Follow up post discharge of people experiencing homelessness has also improved.

The team are, however, aware that there are many more areas in which they can improve on.

Plans for next year include:

- Continue to elevate team's presence in the hospital, especially in light of the changes the Home First Hub and Reablement Teams will bring
- To promote speedier referrals to both health and housing
- More training to front-line staff involved in caring for people experiencing homelessness
- The development of intranet resources
- A greater focus on frequent attenders

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